Missouri Medicaid Hospital Billing Book

Published by the Provider Education Unit
Division of Medical Services
Department of Social Services

MISSOURI MEDICAID
HOSPITAL BILLING BOOK

Table of Contents

PREFACE

This hospital training booklet contains information to help providers submit claims correctly. The information is only for Missouri Medicaid providers and billers if the provider's Medicaid provider number begins with "01". The booklet is not all-inclusive of program benefits and limitations; providers should refer to specific program manuals for the entire content.

SECTION 1
MEDICAID PROGRAM RESOURCES
Informational Resources available at www.dss.mo.gov/dms

CONTACTING MEDICAID

PROVIDER COMMUNICATIONS

The following phone numbers are available for Medicaid providers to call with inquiries, concerns or questions regarding proper claim filing, claims resolution and disposition, and recipient eligibility questions and verification. The (573) 635-8908 number provides an interactive voice response (IVR) system that can address recipient eligibility, last two check amounts and claim status inquiries. Providers must use a touchtone phone to access the IVR. There is no option to be transferred to the Provider Communications Unit from the IVR. See page 1.3 for more information on the IVR.

Provider Communications	(573) 751-2896
Interactive Voice Response (IVR)	(573) 635-8908

The Provider Communications Unit also processes written inquires. Written inquiries should be sent to:

Provider Communications Unit
Division of Medical Services
PO Box 6500
Jefferson City, Missouri 65102

INFOCROSSING HEALTHCARE SERVICES, INC. HELP DESK

(573) 635-3559

Call this number for assistance in establishing the required electronic claims and remittance advice formats, network communication, HIPAA trading partner agreements and assistance with the Infocrossing Internet billing service.

PROVIDER ENROLLMENT

Providers can contact Provider Enrollment via E-mail as follows for questions regarding enrollment applications: providerenrollment@dss.mo.gov.

Changes regarding address, ownership, tax identification number, name (provider or practice), or Medicare number must be submitted in writing to:

Provider Enrollment Unit
Division of Medical Services
PO Box 6500
Jefferson City, Missouri 65102

THIRD PARTY LIABILITY
(573) 751-2005
Call the Third Party Liability Unit to report injuries sustained by Medicaid recipients, problems obtaining a response from an insurance carrier, or unusual situations concerning third party insurance coverage for a Medicaid recipient.

PROVIDER EDUCATION
(573) 751-6683
Provider Education Unit staff are available to educate providers and other groups on proper billing methods and procedures for Medicaid claims. Contact the Unit for training information and scheduling.

RECIPIENT SERVICES
(800) 392-2161 or (573) 751-6527
The Recipient Services Unit assists recipients regarding access to providers, eligibility, covered and non-covered services and unpaid medical bills.

MEDICAID EXCEPTIONS AND DRUG PRIOR AUTHORIZATION HOTLINE
(800) 392-8030
Providers can call this toll free number to initiate an emergency request for an essential medical service or an item of equipment that would not normally be covered under the Medicaid program, or to request a drug prior authorization. The Medicaid exceptions fax line for non-emergency requests only is (573) 522-3061; the fax line to obtain a drug prior authorization is (573) 636-6470.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) INFORMATION

Billing providers who want to exchange electronic information transactions with Missouri Medicaid can access the *HIPAA-EDI Companion Guide* online by going to the Division of Medical Services Web page at www.dss.mo.gov/dms and clicking on the "Providers" link at the top of the page. On the Provider Participation page, click on the HIPAA-EDI Companion Guide link in the column on the left hand side of the page. This will take you directly to the EDI Companion Guide and X12N Version 4010A1 Companion Guide links.

For information on the Missouri Medicaid Trading Partner Agreement, click on the link to Section 1- Getting Started, then select Trading Partner Registration.

All questions concerning the Trading Partner Agreement or provider testing schedules are to be directed to the Infocrossing Healthcare Services Help Desk, (573) 635-3559.

INTERACTIVE VOICE RESPONSE (IVR)
(573) 635-8908

The Provider Communications Unit Interactive Voice Response (IVR) system, (573) 635-8908, requires a touchtone phone. The nine-digit Medicaid provider number **must** be entered each time any of the IVR options are accessed. Callers are limited to ten inquiries per call on any of the options. Providers whose numbers are inactive may utilize the IVR only for dates of service during their active status.

Option 1 — Recipient Eligibility

Recipient eligibility **must** be verified **each** time a recipient presents and should be verified **prior** to the service. Eligibility information can be obtained by a recipient's Medicaid number (DCN), social security number and date of birth, or if a newborn, using the mother's Medicaid number and the baby's date of birth. Callers cannot inquire on dates that exceed one year prior to the current date. Callers will be given a confirmation number and this number should be kept as proof of the information received.

Option 2 — Last Two Check Amounts

Using this option, the caller will be given the last two Remittance Advice (RA) dates, RA numbers, and check amounts.

Option 3 — Claim Status

After entering the recipient's Medicaid number (DCN) and the date of service, the caller will be provided the status of the most current claim in the system containing the date of service entered. The caller will be told whether the claim is paid, denied, approved to pay or is being processed. In addition, the system will give the amount paid, the RA date and the Internal Control Number (ICN).

INTERNET SERVICES FOR MEDICAID PROVIDERS

The Division of Medical Services (DMS), in cooperation with Infocrossing Healthcare Services, has an Internet service for Missouri Medicaid providers. Missouri Medicaid providers have the ability to:

- Submit claims and receive claim confirmation files;
- Verify recipient eligibility;
- Obtain remittance advices (RAs);
- Submit adjustments;
- Submit attachments;
- View claim, attachment and prior authorization (PA) status; and
- View and download public files.

The Web site address for this service is www.emomed.com. Without proper authorization, providers are unable to access the site. Only providers who are approved to be electronic billers can enroll and utilize the Web site services. To participate in the service, the provider must apply on-line at www.dss.mo.gov/dms/providers.htm. Each user is required to complete this on-line application in order to obtain a user ID and password. The application process only takes a few minutes and provides the applicant with a real-time confirmation response, user ID and password. Once the user ID and password have been received, the user can begin using the www.emomed.com Web site. The password can be changed to one of the user's own choice.

Questions regarding the completion of the on-line Internet application should be directed to the Infocrossing Healthcare Services Help Desk, (573) 635-3559.

An authorization is required for each individual person within a provider's office or a billing service who will be accessing the Internet site.

This Web site, www.emomed.com, allows for the submission of the following HIPAA compliant transactions:

837 Institutional Claims	Batched or Individual
837 Professional Claims	Batched or Individual
837 Dental Claims	Batched or Individual
270 Eligibility Inquiry	Batched or Individual
276 Claim Status Inquiry	Batched or Individual

The following standard responses are generated:

835 Remittance Advice	Batch or Printable RA
271 Eligibility Response	Batch or Individual
277 Claim Status Response	Batch or Individual

Users also have access to provider check amounts and the Claims Processing Schedule for the current fiscal year.

There is no cost for this service except for the cost of an Internet service provider access to the Internet. Additionally, there are no special software requirements. However, the user (provider) must have the proper Web browser. The provider must have one of the following Web browsers: Internet Explorer 5.0 or higher or Netscape 4.7 or higher. The Internet site is available 24 hours a day, 7 days a week with the exception of being down for scheduled maintenance.

VERIFYING RECIPIENT ELIGIBILITY THROUGH THE INTERNET

Providers can access Missouri Medicaid recipient eligibility files via the Web site. Functions include eligibility verification by recipient ID, casehead ID and child's date of birth, or Social Security number and date of birth. Eligibility verification can be performed on an individual basis or in a batch file. Individual eligibility verification occurs in real-time basis similar to the Interactive Voice Response System, which means a response is returned immediately. Batch eligibility verifications are returned to the user within 24 hours.

A batch eligibility confirmation file can either be downloaded for viewing purposes or to be printed.

MEDICAID CLAIMS SUBMISSION THROUGH THE INTERNET

The following claim types, as defined by HIPAA Transaction and Code Set regulations, can be used for Internet claim submissions:

- 837 - Health Care Claim
  - Professional
  - Dental
  - Institutional (hospital inpatient and outpatient, nursing home, and home health care)
- Pharmacy (NCPDP)

The field requirements and filing instructions are similar to those for paper claim submissions. For the provider's convenience, some of the claim input fields are set as indicators or accepted values in drop-down boxes. Providers have the option to input and submit claims individually or in a batch submission. A confirmation file is returned for each transmission.

A batch claim confirmation file can either be downloaded for viewing purposes or to be printed.

Note – Currently, some claims cannot be submitted electronically if an attachment is required unless the attachment is one of the following that can be submitted via the Infocrossing Internet Web service: Sterilization Consent, Second Surgical Opinion,

Acknowledgement of Receipt of Hysterectomy Information, the PI-118 Referral (Lock-In) forms, Certificate of Medical Necessity or the Invoice of Cost.

OBTAINING A REMITTANCE ADVICE THROUGH THE INTERNET

The Medicaid program phased out the mailing of paper Remittance Advices (RAs). Providers no longer receive both paper and electronic RAs. If the provider or the provider's billing service currently receives an electronic RA, (either via the emomed.com Internet Web site or other method), paper copies of the RA were discontinued. All providers and billers must have Internet access to obtain the printable electronic RA via the Infocrossing Internet service, emomed.com.

Receiving the Remittance Advice via the Internet is beneficial to the provider or biller's operation. With the Internet RA, a user can:

- Retrieve the RA the Monday following the weekend claim processing cycle (two weeks earlier than receipt of the paper RA);
- Have access to RAs for 62 days (the equivalent of the last four cycles);
- View and print the RA from the desktop; and,
- Download the RA into the provider or biller's operating system for retrieval at a later date.

The Internet RA is viewable and printable in a ready to use format. Just point and click to print the RA or save it to the computer system for printing at the user's convenience.

To sign up for this service, see the instructions at the beginning of this information on Internet services. If a provider does not have access to the Internet, contact the Infocrossing Help Desk, (573) 635-3559, to learn how to obtain a paper remittance.

ADJUSTMENTS THROUGH THE INTERNET

Providers have options on the Internet Medical, Dental, Inpatient, Outpatient and Nursing Home claims for a "Frequency Code" that will allow either a 7 – Replacement (Adjustment) or an 8 – Void (Credit). This will control an individual adjustment or void, but not group adjustments or voids. Claim adjustments and credits can be submitted by utilizing the CLM, field CLMO5-3, segment of the 837 Health Care Claim.

RECEIVE PUBLIC FILES THROUGH THE INTERNET

Several public files are available for viewing or downloading from the Web site including the claims processing schedule for the State fiscal year which begins July 1 and ends June 30. Providers also have access to a listing of the HIPAA related claim codes and other HIPAA related codes.

SUBMIT ATTACHMENTS AND FORMS THROUGH THE INTERNET

Providers can submit required attachments and forms via the Internet as an option to mailing paper versions to Medicaid. A paper copy of any attachment or form submitted via the Internet must be kept with the patient's record. The following forms can be submitted through the Infocrossing Internet service.

Sterilization Consent,
Invoice of Cost
Second Surgical Opinion,
Certificate of Medical Necessity
PI 118 Referral (administrative lock-in), and,
Acknowledgment of Receipt of Hysterectomy Information

MISSOURI MEDICAID PROVIDER MANUALS AND BULLETINS ON-LINE
www.dss.mo.gov/dms

Missouri Medicaid provider manuals are available on-line at the DMS Web site, www.dss.mo.gov/dms. To access the provider manuals, click on the “Providers” link at the top of the DMS Home page. Scroll to the bottom of the Provider Participation page and click on the "Provider Manuals" link. The next page displays an alphabetical listing of all Medicaid provider manuals. To print a manual or a section of a manual, click on the "Synchronize Contents" link on the left hand side of the page, this will bring you to the “Print a Manual” link. Instructions for printing manuals or sections of manuals are available through this link.

Missouri Medicaid provider bulletins are also available at the DMS Web site. The bulletins are published to notify providers of new program and policy changes or to clarify existing policy. To access the bulletins, click on the Provider Bulletin link on the Provider Participation page. The bulletins appear on-line at this location until the provider manuals are updated with the information contained in the bulletins. Once the manuals are updated, the bulletins are moved to the Archived Bulletin location.

CLAIMS PROCESSING SCHEDULE FOR STATE FISCAL YEAR 2007

Cycle Run/Remittance Date* -	Check Date -
Friday, June 23, 2006	Wednesday, July 5, 2006
Friday, July 7, 2006	Thursday, July 20, 2006
Friday, July 21, 2006	Monday, August 7, 2006
Friday, August 4, 2006	Monday, August 21, 2006
Friday, August 18, 2005	Tuesday, September 5, 2006
Friday, September 8, 2006	Wednesday, September 20, 2006
Friday, September 22, 2006	Thursday, October 5, 2006
Friday, October 6, 2006	Friday, October 20, 2006
Friday, October 20, 2006	Monday, November 6, 2006
Friday, November 3, 2006	Monday, November 20, 2006
Friday, November 17, 2006	Tuesday, December 5, 2006
Friday, December 8 2006	Wednesday, December 20, 2006
Friday, December 22, 2006	Friday, January 5, 2007
Friday, January 5, 2007	Monday, January 22, 2007
Friday, January 19, 2007	Monday, February 5, 2007
Friday, February 9, 2007	Tuesday, February 20, 2007
Friday, February 23, 2007	Monday, March 5, 2007
Friday, March 9, 2007	Tuesday, March 20, 2007
Friday, March 23, 2007	Thursday, April 5, 2007
Friday, April 6, 2007	Friday, April 20, 2007
Friday, April 20, 2007	Tuesday, May 8, 2007
Friday, May 4, 2007	Monday, May 21, 2007
Friday, May 18, 2007	Tuesday, June 5, 2007
Friday, June 8, 2007	Wednesday, June 20, 2007

*The Cycle Run Dates are tentative dates calculated by the Division of Medical Services. The dates are subject to change without prior notification.

*All claims submitted electronically to Infocrossing, must be received by 5:00 p.m. of the Cycle Run/Remittance Advice date in order to pay on the corresponding check date.

State Holidays

July 4, 2006 Independence Day
September 4, 2006 Labor Day
October 9, 2006 Columbus Day
November 10, 2006 Veteran's Day
November 23, 2006 Thanksgiving
December 25, 2006 Christmas

January 1, 2007 New Year's Day
January 15, 2007 Martin Luther King Day
February 12, 2007 Lincoln's Birthday
February 19, 2007 Washington's Birthday
May 7, 2007 Truman's Birthday
May 28, 2007 Memorial Day

SECTION 2
UB-92 CLAIM FILING INSTRUCTIONS
INPATIENT HOSPITAL

The following instructions pertain to inpatient hospital claims which are being filed to Medicaid on a paper UB-92 claim form. The requirements for filing an electronic version of the UB-92 claim form for inpatient services are slightly different. If filing claims electronically via the Infocrossing Internet service at www.emomed.com, refer to the help link at the bottom of the electronic UB-92 claim form. If filing electronically using the 837 Institutional Claim, refer to the Implementation Guide for information.

The UB-92 paper claim form should be legibly printed by hand or electronically. It may be duplicated if the copy is legible. Medicaid paper claims for hospital inpatient care are mailed to:

Infocrossing Healthcare Services, Inc.
P.O. Box 5100
Jefferson City, MO 65102

Information about ordering claim forms and provider labels is in Section 3 of the Medicaid *Providers Manual* available at www.dss.mo.gov/dms.

NOTE: An asterisk (*) beside field numbers indicates required fields on all inpatient UB-92 forms. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicate a field is required in specific situations.

FIELD NUMBER AND NAME		INSTRUCTIONS FOR COMPLETION
1.*	Unlabeled Field	Enter the provider name and address exactly as it appears on the provider label. The 9-digit provider number **must** either be entered in this field or in field 51. For convenience, affix the provider label issued by the fiscal agent. This preprinted label contains all the required information. When affixing the label, do **not** cover other fields. Claim forms may be ordered from the fiscal agent with this required information preprinted on the form.
2.	Unlabeled Field	Leave blank.

3.	Patient Control Number	Enter the patient's account number assigned by the hospital.
4.*	Type of Bill	The required three digits in this code identify the following: 1st digit: type of facility 2nd digit: bill classification 3rd digit: frequency The allowed values for each of the digits found in the type of bill are: Type of Facility: 1st digit (1) Hospital Bill Classification: 2nd digit (1) Inpatient (Including Medicare Part A) (2) Inpatient (Medicare Part B only) Frequency: 3rd digit (1) Admit thru Discharge Claim (2) Interim Bill - first claim (3) Interim Bill - continuing claim (4) Interim Bill - last claim
5.	Federal Tax Number	Leave blank.
6.*	Statement Covers Period (from and through dates)	Indicate the beginning and ending dates being billed on this claim form. Enter in MMDDYY numeric format. It **should** include the discharge date as the thru date when billing for the entire stay. Unless noted below, it **should** include all days of the hospitalization. It **should not** include date(s) of patient ineligibility. It **should not** include inpatient days that were **not** certified by the Medicaid certifying agent, such as pre-op days or days beyond the certified through date.
7.*	Covered Days	Enter the number of days shown in field 6, minus the date of discharge. The discharge date is **not** a covered day and should **not** be included in the calculation of field 7. The

		through date of service in field 6 is included in the covered days, if the patient status code in field 22 is equal to "30 - still a patient". **NOTE:** The units entered in this field **must** be equal to the number of days in "Statement Covers Period" less the day of discharge. If the patient status is "30 - still a patient", units entered include the through day.
8.**	Non-covered Days	If applicable, enter the number of non-covered days. An example of non-covered days is those days for which the patient is not eligible. **NOTE:** The total units entered in fields 7 and 8 **must** be equal to the total accommodation units listed in field 46.
9.	Coinsurance Days	Leave blank.
10.	Lifetime Reserve Days	Leave blank.
11.	Unlabeled Field	Leave blank.
12.*	Patient Name	Enter the patient's name as shown on the Medicaid ID card in the following format: last name, first name.
13.	Patient Address	Leave blank.
14.	Patient Birth Date	Leave blank.
15.	Patient Sex	Leave blank.
16.	Patient Marital Status	Leave blank.
17.*	Admission Date	Enter the date the patient was admitted for inpatient care in MMDDYY format. This should be the **actual** date of admission regardless of the patient's eligibility status on that date or the Medicaid utilization review agent's certification/denial of the admission date.
18.	Admission Hour	Leave blank.

19.* Type of Admission

Enter the appropriate type of admission. The allowed values are:

1 - Emergency
2 - Urgent
3 - Elective
4 - Newborn

20.** Source of Admission (SRC)

If this is a transfer admission, complete this field. The allowed values are:

Type of Admission 1, 2, and 3 values are:
1 - Physician referral
2 - Clinic Referral
3 - HMO referral
4 - Transfer from a hospital
5 - Transfer from a skilled nursing facility
6 - Transfer from another health care facility
7 - Emergency room
8 - Court/law enforcement
9 - Information not available
A - Transfer from a critical access hospital

Type of Admission 4 values are:
1 - Normal Delivery
2 - Premature delivery
3 - Sick baby
4 - Extramural birth

21. Discharge Hour

Leave blank.

22.* Status

Enter the 2-digit patient status code that best describes the patient's discharge status.

Common values are:
01 - Discharged to home or self-care
02 - Discharged/transferred to another short-term general hospital for inpatient care
03 - Discharged/transferred to skilled nursing facility
04 - Discharged/transferred to an intermediate care facility

05 - Discharged/transferred to another type of institution for inpatient care
06 - Discharged/transferred to home under care of an organized home health service
07 - Left against medical advice, or discontinued care
08 - Discharged/transferred to home under care of Home IV provider
20 - Expired
30 - Still a patient
50 - Hospice - home
51 - Hospice - medical facility
62 - Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital
64 - Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65 - Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital

23. Medical/Health Record Number

Enter the number that identifies the patient's medical record within the facility.

24.*-30.* Condition Codes

Enter the appropriate two-character condition code(s). The values applicable to Medicaid are:

C1 - Approved as billed. Indicates the facility's utilization review authority has certified all the days billed.
C3 - Partial Approval. The stay being billed on this claim has been approved by the UR as appropriate; however, some portion of the days billed have been denied. **If C3 is entered, field 36 must be completed.**

NOTE: Code C1 or C3 is required.

A1 - EPSDT/Healthy Children and Youth. If this hospital stay is the result of an HCY referral or is an HCY related stay, this condition code **must** be entered on the claim.

A4 - Family Planning. If family planning services occurred during the inpatient stay, this condition code **must** be entered.

31. Unlabeled Field — Leave blank.

32.** - 35.** Occurrence Codes — If one or more of the following occurrence codes apply, enter the appropriate code(s) on the claim:

- 01 - Auto accident
- 02 - No fault insurance
- 03 - Accident/Tort Liability
- 04 - Accident/Employment Related
- 05 - Accident/No medical or liability coverage
- 06 - Crime Victim
- 42 - To be entered when " through" date in field 6 is **not** equal to the discharge date and the frequency code in field 4 indicates that this is a final bill.

36.** Occurrence Span — Is required if C3 is entered in fields 24-30. Enter "MO" and the first and last days that were approved by the hospital's utilization review department.

37.** Internal Control Number (Medicaid resubmission) — For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim indicating the claim was initially submitted within the 12 month timely filing limit.

38. Unlabeled Field — Leave blank.

39-41. Value Codes and Amounts — Leave blank.

42.* Revenue Code — Enter the appropriate 4-digit revenue code. Section 3 of this book lists the covered and non-covered inpatient hospital revenue codes. List the accommodation revenue codes first in chronological order. Ancillary codes should be shown in numerical order.

Show duplicate revenue codes for accommodations when the rate differs or when

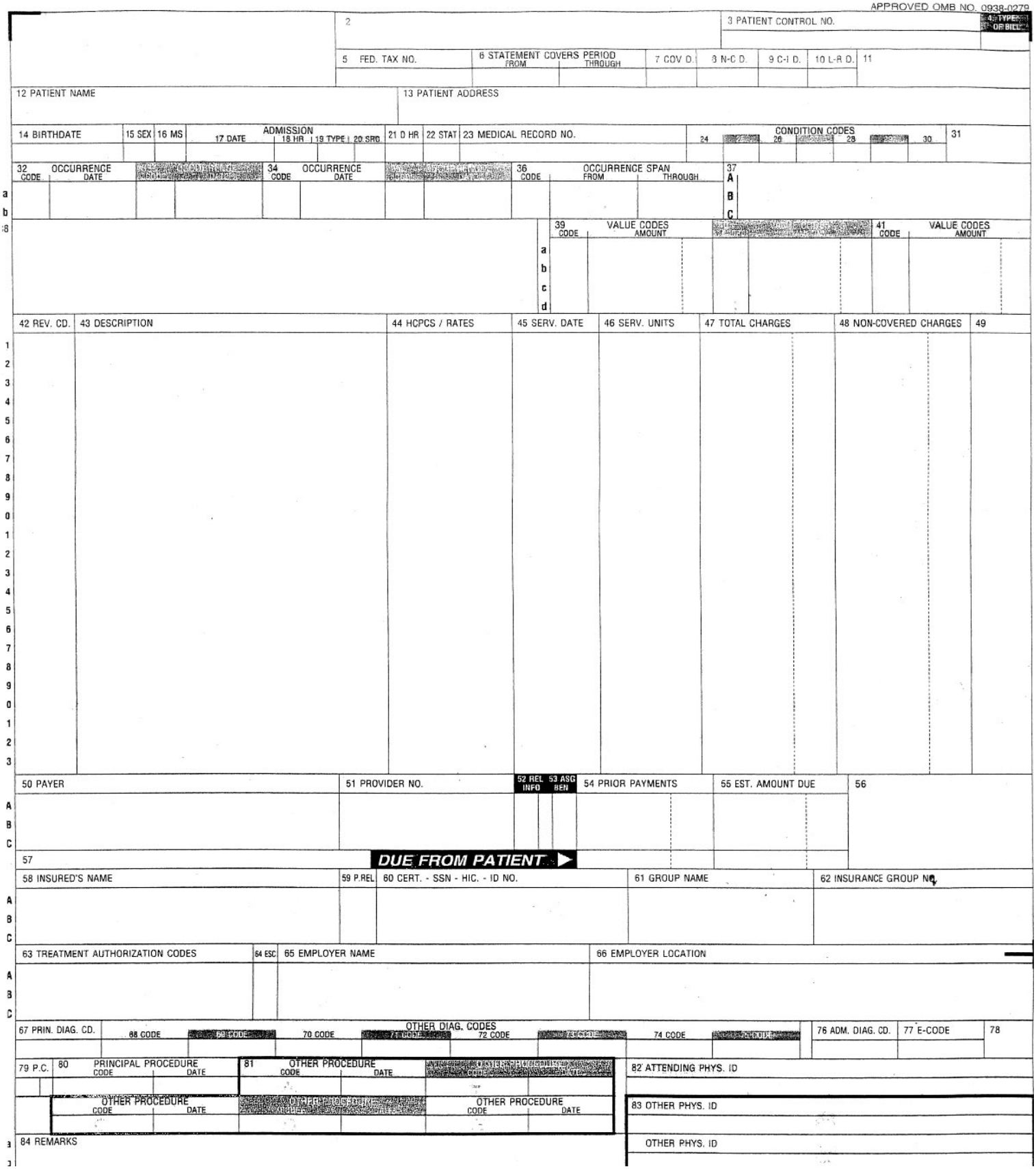
		transfers are made back and forth, e.g., general to ICU to general. When billing for a private room that was medically necessary, a completed *Certificate of Medical Necessity* form **must** be submitted unless the hospital has only private rooms. The private room rate times the number of days is entered as the charge. If the patient requested a private room, which is non-covered, multiply the private room rate by the number of days for the total charge in field 47. Enter the difference between the private room total charge and the semi-private room total charge in field 48, non-covered charges. After all revenue codes are shown, skip a line and enter revenue code 0001 which represents the total charges.
43.	Revenue Description	Leave blank.
44.*	HCPCS/Rates	Enter the daily room and board rate to coincide with the accommodation revenue code. When multiple rates exist for the same accommodation revenue code, use separate lines to report each rate.
45.	Service Date	Leave blank.
46.*	Service Units	Enter the number of units for the accommodation line(s) only. This field should show the total number of days hospitalized, including covered and non-covered days. NOTE: The number of units in fields 7 and 8 **must** equal the number of units in this field.
47.*	Total Charges	Enter the total charge for each revenue code listed. When all charge(s) are listed, skip one line and state the total of these charges to correspond with revenue code 0001.

		NOTE: The room rate multiplied by the number of units **must** equal the charge entered for room accommodation(s).
48.**	Non-covered Charges	Enter any non-covered charges. This includes all charges incurred during those non-covered days entered in field 8. If Medicare Part B was billed, those Part B charges should be shown as non-covered. The difference in charges for private versus non-private room accommodations when the private room was **not** medically necessary should be shown as non-covered in this field.
49.	Unlabeled Field	Leave blank.
50.*	Payer Identification	Indicate if the patient has a secondary payer by listing the name of the payer on the first line. The primary payer is always listed first; e.g., if the patient has insurance, the insurance plan is the primary payer and “Medicaid” is listed last.
51.**	Provider Number	If the Medicaid provider number was **not** entered in field 1, it must be shown here.
52.	Release of Information Certification Indicator	Leave blank.
53.	Assignment of Benefits Certification of Indicator	Leave blank.
54.**	Prior Payments	Enter the amount received for each payer(s). Previous Medicaid payments, Medicare payments, cost sharing and co-pay amounts are **not** to be entered in this field. This field is required if other payer information was indicated in field 50. Payments **must** correspond with the appropriate payer entered in field 50. [See Note (1)]
55.	Estimated Amount Due	Leave blank.
56.	Unlabeled Field	Leave blank.
57.	Unlabeled Field	Leave blank.

58.**	Insured's Name	Complete if the insured's name is different from the patient's name. [See Note (1)]
59.	Patient's Relationship to Insured	Leave blank.
60.*	Certificate/SSN Number/ Health Insurance Claim/ Identification Number	Enter the patient's eight-digit Medicaid number as shown on the Medicaid ID card. If insurance was indicated in field 50, enter the insurance number to correspond with the order shown in field 50.
61.**	Group Name	If insurance is shown in field 50, state the name of the group or plan through which the insurance is provided to the insured. [See Note (1)]
62.**	Insurance Group Number	If insurance is shown in field 50, state the number assigned by the insurance company to identify the group under which the individual is covered. [See Note (1)]
63.**	Treatment Authorization Code	For claims requiring certification, enter the unique 7-digit certification number provided by the Medicaid utilization review agent.
64.	Employment Status Code	Leave blank.
65.	Employer Name	Leave blank.
66.	Employer Location	Leave blank.
67.*	Principal Diagnosis Code	Enter the complete ICD-9-CM diagnosis code for the condition established after study to be chiefly responsible for the admission.
68.**-75.**	Other Diagnosis Codes	Enter any additional ICD-9-CM diagnosis codes that have an effect on the treatment received or the length of stay.
76.	Admitting Diagnosis	Leave blank.
77.	E-Code	Leave blank.
78.	Unlabeled Field	Leave blank.

79.	PC (Procedure Coding Method)	Leave blank.
80.**	Principal Procedure Code and Date	Enter the complete ICD-9 procedure code for the principal procedure and the date the procedure was performed. Only the month and day are required. Do **not** use the decimal point when entering the code on the claim.
81.**	Other Procedure Codes and Dates	If more than one procedure was performed, enter the appropriate ICD-9 procedure code(s) and date(s) the procedure(s) was (were) performed. Only the month and day are required. Do **not** use the decimal point when entering the code(s) on the claim.
82.*	Attending Physician ID	Enter the attending physician's Missouri (or other state) license number, Missouri Medicaid provider number or UPIN number.
83.**	Other Physician ID	Complete, if applicable. Enter the admitting physician's Missouri (or other state) license number, Missouri Medicaid provider number or UPIN number.
84.**	Remarks	Use this field to draw attention to attachments such as operative notes, TPL denial, Medicare Part B only, etc.
85.	Provider Representative	Leave blank.
86.	Date	Leave blank.

(1) NOTE: This field is for private insurance information only. If no private insurance is involved, **LEAVE IT BLANK**. If Medicare, Medicaid, employer's name or other information appears in this field, the claim will deny.


APPROVED OMB NO. 0938-0279
2
3 PATIENT CONTROL NO.
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7 COV D.
8 N-C D.
9 C-I D.
10 L-R D.
11
12 PATIENT NAME
13 PATIENT ADDRESS
14 BIRTHDATE
15 SEX
16 MS
17 DATE
ADMISSION
18 HR
19 TYPE
20 SRC
21 D HR
22 STAT
23 MEDICAL RECORD NO.
24
CONDITION CODES
26
28
30
31
32 CODE OCCURRENCE DATE
34 CODE OCCURRENCE DATE
36 CODE OCCURRENCE SPAN FROM THROUGH
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A
B
C
39 CODE VALUE CODES AMOUNT
41 CODE VALUE CODES AMOUNT
42 REV. CD.
43 DESCRIPTION
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46 SERV. UNITS
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48 NON-COVERED CHARGES
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50 PAYER
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55 EST. AMOUNT DUE
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57
DUE FROM PATIENT
58 INSURED'S NAME
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60 CERT. - SSN - HIC. - ID NO.
61 GROUP NAME
62 INSURANCE GROUP NO.
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64 ESC
65 EMPLOYER NAME
66 EMPLOYER LOCATION
67 PRIN. DIAG. CD.
OTHER DIAG. CODES
68 CODE
70 CODE
72 CODE
74 CODE
76 ADM. DIAG. CD.
77 E-CODE
78
79 P.C.
80 PRINCIPAL PROCEDURE CODE DATE
81 OTHER PROCEDURE CODE DATE
OTHER PROCEDURE CODE DATE
OTHER PROCEDURE CODE DATE
OTHER PROCEDURE CODE DATE
82 ATTENDING PHYS. ID
83 OTHER PHYS. ID
84 REMARKS
OTHER PHYS. ID

SECTION 3
REVENUE CODES - INPATIENT

COVERED REVENUE CODES – INPATIENT SERVICES

A. ACCOMODATIONS

Code	Description	Abbreviation
010X	**All Inclusive Rate**	
0101	All-Inclusive Room and Board	ALL INCL R&B
011X	**Room and Board - Private (Medical or General)**	
0110	General Classification	ROOM-BOARD/PVT
0111	Medical/Surgical/Gyn	MED-SUR-GY/PVT
0112	Obstetric	OB/PVT
0113	Pediatric	PEDS/PVT
0114	Psychiatric	PSYCH/PVT
0116	Detoxification	DETOX/PVT
0117	Oncology	ONCOLOGY/PVT
0118	Rehabilitation	REHAB/PVT
0119	Other	OTHER/PVT
012X	**Room and Board - Semi-Private Two Bed (Medical or General)**	
0120	General Classification	ROOM-BOARD/SEMI
0121	Medical/Surgical/Gyn	MED-SUR-GYN/2BED
0122	OB	OB/2BED
0123	Pediatric	PEDS/2BED
0124	Psychiatric	PSTAY/2BED
0126	Detoxification	DETOX/2BED
0127	Oncology	ONCOLOGY/2BED
0128	Rehabilitation	REHAB/2BED
0129	Other	OTHER/2BED
013X	**Room and Board - Semi-Private - Three and Four Beds**	
0130	General Classification	ROOM-BOARD/3&4BED
0131	Medical/Surgical/Gyn	MED-SUR-GY/3&4BED
0132	OB	OB/3&4BED
0133	Pediatric	PEDS/3&4BED
0134	Psychiatric	PSYCH/3&4BED
0136	Detoxification	DETOX/3&4BED
0137	Oncology	ONCOLOGY/3&4BED
0138	Rehabilitation	REHAB/3&4BED
0139	Other	OTHER/3&4BED

COVERED REVENUE CODES – INPATIENT SERVICES (Continued)

014X Room and Board - Private (Deluxe)

0140	General Classification	ROOM-BOARD/PVT/DLX
0141	Medical/Surgical/Gyn	MED-SUR-GY/DLX
0142	OB	OB/DLX
0143	Pediatric	PEDS/DLX
0144	Psychiatric	PSYCH/DLX
0146	Detoxification	DETOX/DLX
0147	Oncology	ONCOLOGY/DLX
0148	Rehabilitation	REHAB/DLX
0149	Other	OTHER/DLX

015X Room and Board – Ward (Medical or General)

0150	General Classification	ROOM-BOARD/WARD
0151	Medical/Surgical/Gyn	MED-SUR-GY/WARD
0152	OB	OB/WARD
0153	Pediatric	PEDS/WARD
0154	Psychiatric	PSYCH/ WARD
0156	Detoxification	DETOX/WARD
0157	Oncology	ONCOLOGY/WARD
0158	Rehabilitation	REHAB/WARD
0159	Other	OTHER/WARD

016X Room and Board - Other

0164	Sterile Environment	R&B/STERILE

017X Nursery

0170	General Classification	NURSERY
0171	Newborn - Level I	NURSERY/LEVELI
0172	Newborn - Level II	NURSERY/LEVELII
0173	Newborn - Level III	NURSERY/LEVELIII
0174	Newborn - Level IV	NURSERY/LEVELIV
0179	Other Nursery	NURSERY/OTHER

020X Intensive Care

0200	General Classification	INTENSIVE CARE (or ICU)
0201	Surgical	ICU/SURGICAL
0202	Medical	ICU/MEDICAL
0203	Pediatric	ICU/PEDS
0204	Psychiatric	ICU/PSTAY
0206	Intermediate ICU	ICU/INTERMEDIATE
0207	Burn Care	ICU/BURN CARE
0208	Trauma	ICU/TRAMA
0209	Other Intensive Care	ICU/OTHER

COVERED REVENUE CODES – INPATIENT SERVICES (Continued)

021X	**Coronary Care**	
0210	General Classification	CORNOARY CARE (or CCU)
0211	Myocardial Infarction	CCU/MYO INFARC
0212	Pulmonary Care	CCU/PULMONARY
0214	Intermediate CCU	CCU/INTERMEDIATE
0219	Other Coronary Care	CCU/OTHER

B. ANCILLARIES

Code	Description	Abbreviation
025X	**Pharmacy**	
0250	General Classification	PHARMACY
0251	Generic Drugs	DRUGS/GENERIC
0252	Non-generic Drugs	DRUGS/NONGENERIC
0254	Drugs Incident to Other Diagnostic Services	DRUGS/INCIDENT/ODX
0255	Drugs Incident to Radiology	DRUGS/ INCIDENT RAD
0257	Non-prescription Drugs	DRUGS/NONPSCRPT
0258	IV Solutions	IV SOLUTIONS
0259	Other Pharmacy	DRUGS/OTHER
026X	**I.V. Therapy**	
0260	General Classification	IV THERAPY
0261	Infusion Pump	IV THER/INFSN PUMP
0262	IV Therapy/Pharmacy Svcs	IV THER/PHARM/SVC
0263	IV Therapy/Drug/Supply Delivery	IV THER/DRUG/SUPPLY DELV
0264	IV Therapy/Supplies	IV THER/SUPPLIES
0269	Other IV Therapy	IV THER/OTHER
027X	**Medical/Surgical Supplies and Devices**	
0270	General Classification	MED-SUR SUPPLIES
0271	Non-Sterile Supply	NON-STER SUPPLY
0272	Sterile Supply	STERILE SUPPLY
0275	Pacemaker	PACE MAKER
0276	Intraocular Lens	INTRA OC LENS
0278	Other Implant	SUPPLY/IMPLANTS
0279	Other Supplies/Devices	SUPPLY/OTHER
028X	**Oncology**	
0280	General Classification	ONCOLOGY
0289	Other Oncology	ONCOLOGY/OTHER

COVERED REVENUE CODES – INPATIENT SERVICES (Continued)

030X	**Laboratory**	
0300	General Classification	LABORATORY or (LAB)
0301	Chemistry	LAB/CHEMISTRY
0302	Immunology	LAB/IMMUNOLOGY
0304	Non-routine Dialysis	LAB/NR DIALYSIS
0305	Hematology	LAB/HEMATOLOGY
0306	Bacteriology & Microbiology	LAB/BACT-MICRO
0307	Urology	LAB/UROLOGY
0309	Other Laboratory	LAB/OTHER
031X	**Laboratory Pathological**	
0310	General Classification	PATHOLOGY LAB or (PATH LAB)
0311	Cytology	PATHOL/CYTOLOGY
0312	Histology	PATHOL/HISTOL
0314	Biopsy	PATHOL/BIOPSY
0319	Other Laboratory Pathological	PATHOL/OTHER
032X	**Radiology - Diagnostic**	
0320	General Classification	DX X-RAY
0321	Angiocardiography	DX X-RAY/ANGIO
0322	Arthrography	DX X-RAY/ARTH
0323	Anteriography	DX X-RAY/ARTER
0324	Chest X-ray	DX X-RAY/CHEST
0329	Other Radiology - Diagnostic	DX X-RAY/OTHER
033x	**Radiology – Therapeutic and/or Chemotherapy Administration**	
0330	General Classification	RX X-RAY
0331	Chemotherapy Administration-Injected	CHEMOTHER/INJ
0332	Chemotherapy Administration-Oral	CHEMOTHER/ORAL
0333	Radiation Therapy	RADIATION RX
0335	Chemotherapy Administration - IV	CHEMOTHERP-IV
0339	Other Radiology - Therapeutic	RX X-RAY/OTHER
034X	**Nuclear Medicine**	
0340	General Classification	NUCLEAR MEDICINE or (NUC MED)
0341	Diagnostic Procedures	NUC MED/DX
0342	Therapeutic Procedures	NUC MED/RX
0343	Diagnostic Radiopharmaceuticals	NUC MED/DX RADIOPHARM
0344	Therapeutic Radiopharmaceuticals	NUC MED/RX RADIOPHARM
0349	Other Nuclear Medicine	NUC MED/OTHER

COVERED REVENUE CODES – INPATIENT SERVICES (Continued)

035X	**CT Scan**	
0350	General Classification	CT Scan
0351	Head Scan	CT SCAN/HEAD
0352	Body Scan	CT SCAN/BODY
0359	Other CT Scan	CT SCAN/OTHER
036X	**Operating Room Service**	
0360	General Classification	OR SERVICES
0361	Minor Surgery	OR/MINOR
0369	Other Operating Room Services	OR/OTHER
037X	**Anesthesia**	
0370	General Classification	ANESTHESIA
0371	Anesthesia Incident to Radiology	ANESTHE/INCIDENT RAD
0372	Anesthesia Incident to Other Diagnostic Services	ANESTH/INCIDENT OTHER DX
0379	Other Anesthesia	ANESTHESIA/OTHER
038X	**Blood**	
0380	General Classification	BLOOD
0381	Packed Red Cells	BLOOD/PKD RED
0382	Whole Blood	BLOOD/WHOLE
0383	Plasma	BLOOD/PLASMA
0384	Platelets	BLOOD/PLATELETS
0385	Leucocytes	BLOOD/LEUCOCYTES
0386	Other Components	BLOOD/COMPONENTS
0387	Other Derivatives (Cryoprecipitates)	BLOOD/DERIVATIVES
0389	Other Blood	BLOOD/OTHER
039X	**Blood and Blood Component Administration, Processing and Storage**	
0390	General Classification	BLOOD/STOR-PROC
0391	Administration (e.g. Transfusion)	BLOOD/ADMIN
0399	Other Processing and Storage	BLOOD/OTHER STOR
040X	**Other Imaging Services**	
0400	General Classification	IMAGE SERVICE
0401	Diagnostic Mammography	DIAG MAMMOGRAPHY
0402	Ultrasound	ULTRASOUND
0403	Screening Mammography	SCRN MAMMOGRAPHY
0409	Other Imaging Services	OTHER IMAG SVS

COVERED REVENUE CODES – INPATIENT SERVICES (Continued)

041X	**Respiratory Services**	
0410	General Classification	RESPIRATORY SVC
0412	Inhalation Services	INHALATION SVC
0413	Hyperbaric Oxygen Therapy	HYPERBARIC O2
0419	Other Respiratory Services	OTHER RESPIR SVS
042X	**Physical Therapy**	
0420	General Classification	PHYSICAL THERAP
0422	Hourly Charge	PHYS THERP/HOUR
0423	Group Rate	PHYS THERP/GROUP
0429	Other Physical Therapy	OTHER PHYS THERP
043X	**Occupational Therapy**	
0430	General Classification	OCCUPATION THER
0432	Hourly Charge	OCCUP THERP/HOUR
0433	Group Rate	OCCUP THERP/GROUP
0434	Evaluation or Re-evaluation	OCCUP THERP/EVAL
0439	Other Occupational Therapy	OTHER OCCUP THER
044X	**Speech - Language Pathology**	
0440	General Classification	SPEECH PATHOL
0442	Hourly Charge	SPEECH PATH/HOUR
0443	Group Rate	SPEECH PATH/GROUP
0444	Evaluation or Re-evaluation	SPEECH PATH/EVAL
0449	Other Speech - Language Pathology	OTHER SPEECH PATH
046X	**Pulmonary Function**	
0460	General Classification	PULMONARY FUNC
0469	Other Pulmonary Function	OTHER PULMON FUNC
048X	**Cardiology**	
0480	General Classification	CARDIOLOGY
0481	Cardiac Cath Lab	CARDIAC CATH LAB
0482	Stress Test	STRESS TEST
0483	Echocardiology	ECHOCARDIOLOGY
0489	Other Cardiology	OTHER CARDIOL
061X	**Magnetic Resonance Technology (MRT)**	
0610	General Classification	MRT
0611	MRI-Brain (including Brainstem)	MRI-Brain
0612	MRI-Spinal Cord (including Spine)	MRI-SPINE
0614	MRI-Other	MRI-OTHER
0615	MRA-Head and Neck	MRA-HEAD AND NECK
0616	MRA-Lower Extremities	MRA-LOWER EXT

COVERED REVENUE CODES – INPATIENT SERVICES (Continued)

061X	**Magnetic Resonance Technology (MRT) (continued)**	
0618	MRA-Other	MRA-OTHER
0619	Other MRT	MRT-OTHER
062X	**Medical/Surgical Supplies**	
0621	Supplies Incident to Radiology	MED-SUR SUPP/INCIDENT RAD
0622	Supplies Incident to Other Diagnostic Services	MED-SUR SUPP/INCIDENT ODX
0623	Surgical Dressings	SURG DRESSINGS
063X	**Pharmacy**	
0631	Single Source Drug	DRUG/SNGLE
0632	Multiple Source Drug	DRUG/MULT
0633	Restrictive Prescription	DRUG/RSTR
0634	Erythropoietin (EPO) less than 10,000 Units	DRUG/EPO <10,000 UNITS
0635	Erythropoietin (EPO) 10,000 or more Units	DRUG/EPO > 10,000 UNITS
0636	Drugs Requiring Detailed Coding	DRUG/DETAIL CODE
071X	**Recovery Room**	
0710	General Classification	RECOVERY ROOM
0719	Other Recovery Room	OTHER RECOVERY RM
072X	**Labor Room/Delivery**	
0720	General Classification	DELIVERROOM/LABOR
0721	Labor	LABOR
0722	Delivery	DELIVERY ROOM
0724	Birthing Center	BIRTHING CENTER
0729	Other Labor Room/Delivery	OTHER/DELIV-LABOR
073X	**EKG/ECG (Electrocardiogram)**	
0730	General Classification	EKG/ECG
0731	Holter Monitor	HOLTER MONT
0739	Other EKG/ECG	OTHER EKG-ECG
074x	**EEG (Electroencephalogram)**	
0740	General Classification	EEG
0749	Other EEG	OTHER EEG
075X	**Gastro-Intestinal Services**	
0750	General Classification	GASTR-INST SVS
0759	Other Gastro-Intestinal	OTHER GASTRO-INTS

COVERED REVENUE CODES – INPATIENT SERVICES (Continued)

079X	**Electro-Corporeal Shock Wave Therapy (formerly Lithotripsy)**	
0790	General Classification	ESWT
0799	Other ESWT	ESWT/OTHER
080X	**Inpatient Renal Dialysis**	
0800	General Classification	RENAL DIALYSIS
0801	Inpatient Hemodialysis	DIALY/INPT
0802	Inpatient Peritoneal (Non-CAPD)	DIALY/INPT/PER
0803	Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)	DIALY/INPT/CAPD
0804	Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)	DIALY/INPT/CCPD
0809	Other Inpatient Dialysis	DIALY/INPT/OTHER
088X	**Miscellaneous Dialysis**	
0880	General Classification	DIALY/MISC
0881	Ultrafiltration	DIALY/ULTRAFILT
0889	Other Miscellaneous Dialysis	DIALY/MISC/OTHER
090X	**Behavioral Health Treatments/Services**	
0900	General Classification	BH
0901	Electroshock Treatment	BH/ELECTRO SHOCK
091X	**Behavioral Health Treatments/Services – Extension of 090X**	
0911	Rehabilitation	BH/REHAB
0914	Individual Therapy	BH/INDIV RX
0915	Group Therapy	PSTAY/GROUP RX
0918	Testing	BH TESTING
0919	Other Behavioral Health Treatments/Services	BH/OTHER
092X	**Other Diagnostic Services**	
0920	General Classification	OTHER DX SVS
0921	Peripheral Vascular Lab	PERI VASCUL LAB
0922	Electromyogram	EMG
0923	Pap Smear	PAP SMEAR
0924	Allergy Test	ALLERGY TEST
0925	Pregnancy Test	PREG TEST
0929	Other Diagnostic Service	ADDITIONAL DX SVS

COVERED REVENUE CODES – INPATIENT SERVICES (Continued)

094X	Other Therapeutic Services	
0940	General Classification	OTHER RX SVS
0941	Recreational Therapy	RECREATION RX
0943	Cardiac Rehabilitation	CARDIAC REHAB
0944	Drug Rehabilitation	DRUG REHAB
0945	Alcohol Rehabilitation	ALCOHOL REHAB
0946	Complex Medical Equipment-Routine	CMPLX MED EQUIP-ROUT
0947	Complex Medical Equipment-Ancillary	CMPLX MED EQUIP-ANC
0949	Other Therapeutic Service	ADDITIONAL RX SVS

NON-COVERED REVENUE CODES – INPATIENT SERVICES

0100	0213	0367	0630	0902-0909
0115	0220-0249	0374	0637	0910
0125	0253	0404	0640-0709	0912-0913
0135	0256	0421	0723	0916-0917
0145	0273-0274	0424	0732	0930-0939
0155	0277	0441	0760-0789	0942
0160	0290-0299	0450-0459	0810-0879	0950-0999
0167-0169	0303	0470-0479	0882	1000-9999
0180-0199	0362	0490-0609	0890-0899	

NOTE: Any service for which there is no assigned revenue code is considered non-covered.

SECTION 4
INPATIENT HOSPITAL SURGICAL PROCEDURE CODES

The International Classification of Diseases, 9th Revision, Clinical Modification, (ICD-9-CM) procedure codes are required by HIPAA standards to be used to report surgical procedures on the inpatient hospital claim form (UB-92). ICD-9 procedure codes must be used on any type of inpatient hospital claim submitted on or after October 16, 2003. Do **not** use a decimal point when entering the code on any claim type.

Refer to the following list for the Missouri Medicaid restrictions regarding the standard code set.

ICD-9 Procedure Code	Restriction
05.23	Certificate of Medical Necessity Required
08.31	Prior Authorization Required
08.32	Prior Authorization Required
08.33	Prior Authorization Required
08.34	Prior Authorization Required
08.35	Prior Authorization Required
08.36	Prior Authorization Required
08.37	Prior Authorization Required
08.7	Prior Authorization Required
08.86	Prior Authorization Required
08.87	Prior Authorization Required
11.71	Not Covered
11.75	Not Covered
11.76	Prior Authorization Required
16.98	Not Covered
18.01	Not Covered
18.5	Prior Authorization Required
21.83	Not Covered
21.84	Not Covered
21.86	Not Covered
21.87	Not Covered
24.2	Not Covered
24.39	Not Covered
24.5	Not Covered
32.22	Not Covered
38.99	Not Covered
39.92	Not Covered
44.38	Prior Authorization Required

ICD-9 Procedure Code	Restriction
44.67	Prior Authorization Required
44.68	Prior Authorization Required
44.95	Prior Authorization Required
44.96	Prior Authorization Required
44.97	Prior Authorization Required
44.98	Prior Authorization Required
59.5	Acknowledgement of Receipt of Hysterectomy Form Required
62.7	Not Covered
62.99	Not Covered
63.73	Sterilization Consent Form Required
64.43	Not Covered
64.5	Not Covered
64.93	Prior Authorization Required
64.95	Not Covered
64.96	Not Covered
64.97	Not Covered
64.98	Prior Authorization Required
64.99	Not Covered
65.31	Acknowledgement of Receipt of Hysterectomy Form Required
65.39	Acknowledgement of Receipt of Hysterectomy Form Required
65.41	Acknowledgement of Receipt of Hysterectomy Form Required
65.49	Acknowledgement of Receipt of Hysterectomy Form Required
65.51	Acknowledgement of Receipt of Hysterectomy Form Required
65.52	Acknowledgement of Receipt of Hysterectomy Form Required
65.53	Acknowledgement of Receipt of Hysterectomy Form Required
65.54	Acknowledgement of Receipt of Hysterectomy Form Required
65.61	Acknowledgement of Receipt of Hysterectomy Form Required
65.62	Acknowledgement of Receipt of Hysterectomy Form Required
65.63	Acknowledgement of Receipt of Hysterectomy Form Required
65.64	Acknowledgement of Receipt of Hysterectomy Form Required
66.02	Not Covered
66.21	Sterilization Consent Form Required
66.22	Sterilization Consent Form Required
66.29	Sterilization Consent Form Required
66.31	Sterilization Consent Form Required
66.32	Sterilization Consent Form Required
66.39	Sterilization Consent Form Required
66.72	Not Covered
66.73	Not Covered
66.74	Not Covered
66.79	Prior Authorization Required
66.8	Prior Authorization Required

ICD-9 Procedure Code	Restriction
66.92	Sterilization Consent Form Required
66.95	Prior Authorization Required
66.96	Prior Authorization Required
68.3	Acknowledgement of Receipt of Hysterectomy Form Required
68.4	Acknowledgement of Receipt of Hysterectomy Form Required
68.51	Acknowledgement of Receipt of Hysterectomy Form Required
68.59	Acknowledgement of Receipt of Hysterectomy Form Required
68.6	Acknowledgement of Receipt of Hysterectomy Form Required
68.7	Acknowledgement of Receipt of Hysterectomy Form Required
68.8	Acknowledgement of Receipt of Hysterectomy Form Required
68.9	Acknowledgement of Receipt of Hysterectomy Form Required
69.01	Certificate of Medical Necessity for Abortion Required
69.51	Certificate of Medical Necessity for Abortion Required
69.92	Not Covered
69.93	Certificate of Medical Necessity for Abortion Required
69.99	Certificate of Medical Necessity for Abortion Required
70.4	Acknowledgement of Receipt of Hysterectomy Form Required
70.79	Prior Authorization Required
70.8	Acknowledgement of Receipt of Hysterectomy Form Required
70.92	Acknowledgement of Receipt of Hysterectomy Form Required
71.4	Prior Authorization Required
71.9	Not Covered
74.91	Certificate of Medical Necessity for Abortion Required
75.99	Certificate of Medical Necessity for Abortion Required
76.68	Prior Authorization Required
78.9	Prior Authorization Required
78.91	Prior Authorization Required
78.92	Prior Authorization Required
78.93	Prior Authorization Required
78.94	Prior Authorization Required
78.95	Prior Authorization Required
78.96	Prior Authorization Required
78.97	Prior Authorization Required
78.98	Prior Authorization Required
78.99	Prior Authorization Required
82.82	Prior Authorization Required
82.83	Prior Authorization Required
83.29	Not Covered
83.92	Prior Authorization Required
85.2	Prior Authorization Required
85.31	Prior Authorization Required
85.32	Prior Authorization Required

ICD-9 Procedure Code	Restriction
85.33	Prior Authorization Required
85.35	Prior Authorization Required
85.5	Prior Authorization Required
85.51	Prior Authorization Required
85.52	Prior Authorization Required
85.53	Prior Authorization Required
85.54	Prior Authorization Required
85.6	Prior Authorization Required
85.7	Prior Authorization Required
85.85	Prior Authorization Required
85.87	Prior Authorization Required
85.93	Prior Authorization Required
85.94	Prior Authorization Required
85.95	Prior Authorization Required
85.96	Prior Authorization Required
85.99	Prior Authorization Required
86.02	Prior Authorization Required
86.05	Prior Authorization Required
86.25	Prior Authorization Required
86.64	Not Covered
86.82	Not Covered
86.83	Prior Authorization Required
86.92	Not Covered
86.93	Prior Authorization Required
87.85	Prior Authorization Required
89.04	Not Covered
96.17	Not Covered
96.49	Certificate of Medical Necessity for Abortion Required
97.24	Not Covered
97.71	Not Covered
99.86	Prior Authorization Required
99.96	Not Covered
99.99	Prior Authorization Required

SECTION 5
INPATIENT REHABILITATION SCHEDULE

Effective for dates of service October 16, 2003 and after, inpatient rehabilitation providers subject to DMS established length of stay should **not** use the special diagnosis codes created by DMS to report the rehabilitation diagnosis. The following table reflects the ICD-9-CM diagnosis codes that are to be used to report the rehabilitation diagnosis for dates of service October 16, 2003 and after. For dates of service prior to October 16, 2003, providers should use the appropriate Missouri Medicaid specific diagnosis codes.

DESCRIPTION	DMS Established Length of Stay	Special Diagnosis Code for Svc. Dates prior to 10/16/03	ICD-9-CM DIAGNOSIS CODE(S) for Svc. Dates 10/16/03 and after
Spinal cord injury, quadriplegia	30 days	SC1	950 - 957
Spinal cord injury, cervical fracture	25 days	SC2	806
Spinal cord injury, paraplegia	30 days	SC3	344
Spinal cord injury, hemiplegia	25 days	SC4	342
Cerebral vascular accident	29 days	CVA	436
Head trauma	35 days	HTI	803, 854
Muscular dystrophy	20 days	MUD	359
Orthopedic trauma, arm	29 days	OT1	885 - 887
Orthopedic trauma, leg	29 days	OT2	895 - 897
Late effect of injury to the nervous system	30 days	ENS	905 - 909
Degenerative joint disease	20 days	DJD	714 - 716

SECTION 6
INPATIENT HOSPITAL CERTIFICATION REVIEWS

Inpatient hospital admissions must be certified as medically necessary and appropriate as inpatient services before Missouri Medicaid reimburses for inpatient services. All hospitals with a Missouri Medicaid provider number beginning with "01" are subject to this admission certification requirement. The review authority is assigned to Health Care Excel (HCE). Inpatient hospital certification reviews are covered in Section 13.31 of the Missouri Medicaid hospital provider manual available at www.dss.mo.gov/dms.

SERVICES EXEMPT FROM ADMISSION CERTIFICATION

The following services do not require admission certification:

Certain Pregnancy-Related Diagnosis Codes

630
631
633 range
640-648 range with a fifth digit of 0 or 3
651-676 range with a fifth digit of 0 or 3

NOTE: Diagnoses for missed abortion, pregnancy with abortive outcome, and postpartum care continue to require certification.

Admissions for Deliveries

Delivery diagnosis codes are:

640-648 range with a fifth digit of 1 or 2
650
651-676 range with a fifth digit of 1 or 2
V24.0
V27.0-V27.9

NOTE: Providers are cautioned to refer to the ICD-9-CM diagnosis coding book because a fifth digit of 1 or 2 is not valid with every diagnosis within the ranges listed above.

Admissions for Newborns

Newborn diagnosis codes are:

V30.00-V39.1 (If the fourth digit is 0, a fifth digit of 0 or 1 is required)
760-779.9

Admissions of Patients Enrolled in MC+ Health Plans

The health plan is responsible for certifying the hospital admission for MC+ enrollees. A transplant candidate may choose the Medicaid approved transplant

facility and may choose a Medicaid approved transplant facility outside of the health plan's network and DMS will prior authorize the transplant. The health plan is responsible for pre-transplant and post-transplant follow-up at both the in-network and the out-of-network transplant facilities.

Admissions Covered By Medicare Part A

Claims for deductible and coinsurance for Medicaid patients with Medicare Part A benefits are exempt from admission certification. However, if Medicare Part A benefits have been exhausted and a claim is submitted for Medicaid only days, admission certification requirements must be met. Admissions for Medicaid patients with Medicare Part B only require certification.

Claims with a principal diagnosis that is one of the exempt codes do not require a certification number in field 63 on the UB-92. HCE does not need to be contacted under these circumstances.

CONTACTING HCE

Providers may contact Health Care Excel at:

Health Care Excel
3230 Emerald Lane, Suite C
P.O. Box 105110
Jefferson City, MO 65110-5110

(800) 766-0686 - for admission certification, continued stay review and other general requests

(573) 634-4262 - Fax for admission and continued stay review

The HCE office is open from 8:00 a.m. to 5:00 p.m., Monday through Friday, except for established DSS approved holidays. Telephone calls made before or after working hours receive a recorded message about the working hours. Admission and continued stay certification requests submitted by fax are accepted by HCE 24 hours a day, every day.

PROVIDER RESPONSIBILITIES

HCE must be contacted by the physician or the hospital to provide patient/provider identifying information and medical information regarding the patient's condition and planned services as set forth in Missouri state regulation 13 CSR 70-15.020.

CONTINUED STAY REQUESTS

Continued stay certification requests must be made one day prior to the last day approved by HCE. The provider is responsible for contacting HCE to request an extended stay beyond what was previously certified.

HCE LETTER OF APPROVAL

After HCE approves an admission, a letter (sample on page 6.4) is sent to both the hospital and the attending physician. The letter confirms the information that was previously provided either by telephone, fax, or a written request. It is important that the information in this letter is verified for accuracy. It is suggested that a copy of the HCE letter be given to the billing department for comparison with the information on the claim that is submitted to Medicaid. This may prevent denials during claims processing. The important information to check in the HCE approval letter is:

1. Patient's Medicaid number (field 60 on the claim)
2. Admission date (field 17 on the claim)
3. Cease payment date
4. Surgery date, if applicable (field 80 on the claim)
5. Certification number (field 63 on the claim)

If there is any information in the HCE approval letter that is different from the hospital's records, HCE must be contacted so the claims processing file information can be updated. For example, if surgery information was given to HCE but not performed, contact HCE. Without an exact match on the above five fields, a claim cannot pay.

There is one exception. If an admission was certified with no surgery indicated at the time of request, the provider is not required to contact HCE if surgery is performed during the inpatient stay.

P.O. Box 105110
Jefferson City, MO 65110-5110

Date: 10/05/2004

NOTICE: APPROVAL OF ADMISSION

Utilization Review Department
TEST HOSPITAL
ADDRESS LINE 1
ADDRESS LINE 2
CITY, ST 99999

Recipient Name: FIRST NAME LAST NAME
Recipient Number: 999
Admission Date: 10/01/2004
Provider Number: 999

Dear Utilization Review Department:

Health Care Excel is designated by the State of Missouri, Department of Social Services (DSS), as the medical review authority responsible for utilization review of DSS specified categories of hospitalization for Missouri Medicaid recipients. Health Care Excel is responsible for making a determination as to whether the services provided or proposed are medically necessary and delivered in the most appropriate setting.

We have completed review of the above referenced admission and determined that the admission was medically necessary. The initial length of stay approved and certified by Health Care Excel is 10/01/2004 through 10/05/2004 for a total of 4 days. If discharge cannot be accomplished on the certified through date, and additional days are needed, please call us **prior** to the last approved day.

Certification number
UB-92 Locator 63: 4279216

Note: The hospital claim will be denied if the certification number is not present.

Admission certification approves the medical necessity of the admission only. It does not guarantee payment nor does it guarantee that the amount billed will be the amount reimbursed. The recipient must be Medicaid eligible for the dates of service billed.

This decision applies only to this hospital admission. Any future hospital admissions must be reviewed for medical necessity independently. If you have any questions, please call us at 1-800-766-0686. Thank you for your support of the medical review process.

Sincerely,

Medical Director

c: DOCTOR TRANSITION MD

rev. MOQ-PAP-03011 - 01/02/2003

SECTION 7
UB-92 CLAIM FILING INSTRUCTIONS
OUTPATIENT HOSPITAL

The following instructions pertain to outpatient hospital claims, which are being filed to Medicaid on a paper UB-92 claim form. The requirements for filing an electronic version of the UB-92 claim form for outpatient services are slightly different. If filing claims electronically via the Infocrossing Internet service, www.emomed.com, refer to the help link at the bottom of the electronic UB-92 claim form. If filing electronically using the 837 Institutional Claim, refer to the Implementation Guide for information.

The UB-92 paper claim form should be legibly printed by hand or electronically. It may be duplicated if the copy is legible. Medicaid paper claims for hospital outpatient care are to be mailed to:

Infocrossing Healthcare Systems, Inc.
P.O. Box 5200
Jefferson City, MO 65102

Information about ordering claim forms and provider labels is in Section 3 of the Medicaid *Providers Manual* available at www.dss.mo.gov/dms.

NOTE: An asterisk (*****) beside field numbers indicates required fields on all outpatient UB-92 claim forms. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (******) beside the field number indicate a field is required in specific situations.

Field number and name		Instructions for completion
1.*	Unlabeled Field	Enter the provider name and address exactly as it appears on the provider label. The 9-digit provider number must either be entered in this field or in field 51. For convenience, affix the provider label issued by the fiscal agent. This preprinted label contains all required information. When affixing the label, do **not** cover other fields. Claim forms may be ordered from the fiscal agent with this required information preprinted on the form.
2.	Unlabeled Field	Leave blank.
3.	Patient Control Number	Enter the patient's account number assigned by the hospital.

4.*	Type of Bill	For an outpatient claim, the only allowed type of bill is “131”.
5.	Federal Tax Number	Leave blank.
6.	Statement Covers Period (from and through dates)	Leave blank.
7.	Covered Days	Leave blank.
8.	Non-covered Days	Leave blank.
9.	Coinsurance Days	Leave blank.
10.	Lifetime Reserve Days	Leave blank.
11.	Unlabeled Field	Leave blank.
12.*	Patient Name	Enter the patient’s name in the following format: last name and first name as shown on the Medicaid ID card.
13.	Patient Address	Leave blank.
14.	Patient Birth Date	Leave blank.
15.	Patient Sex	Leave blank.
16.	Patient Marital Status	Leave blank.
17.	Admission Date	Leave blank.
18.	Admission Hour	Leave blank.
19.	Type of Admission	Leave blank unless this claim is for an emergency room service. If so, enter Admission Type 1. Condition Code AJ also must be listed in field 24 to exempt the patient from the $2.00 cost sharing amount for the service.
20.	SRC (Source of Admission)	Leave blank.
21.	Discharge Hour	Leave blank.
22.	Patient Status	Leave blank.

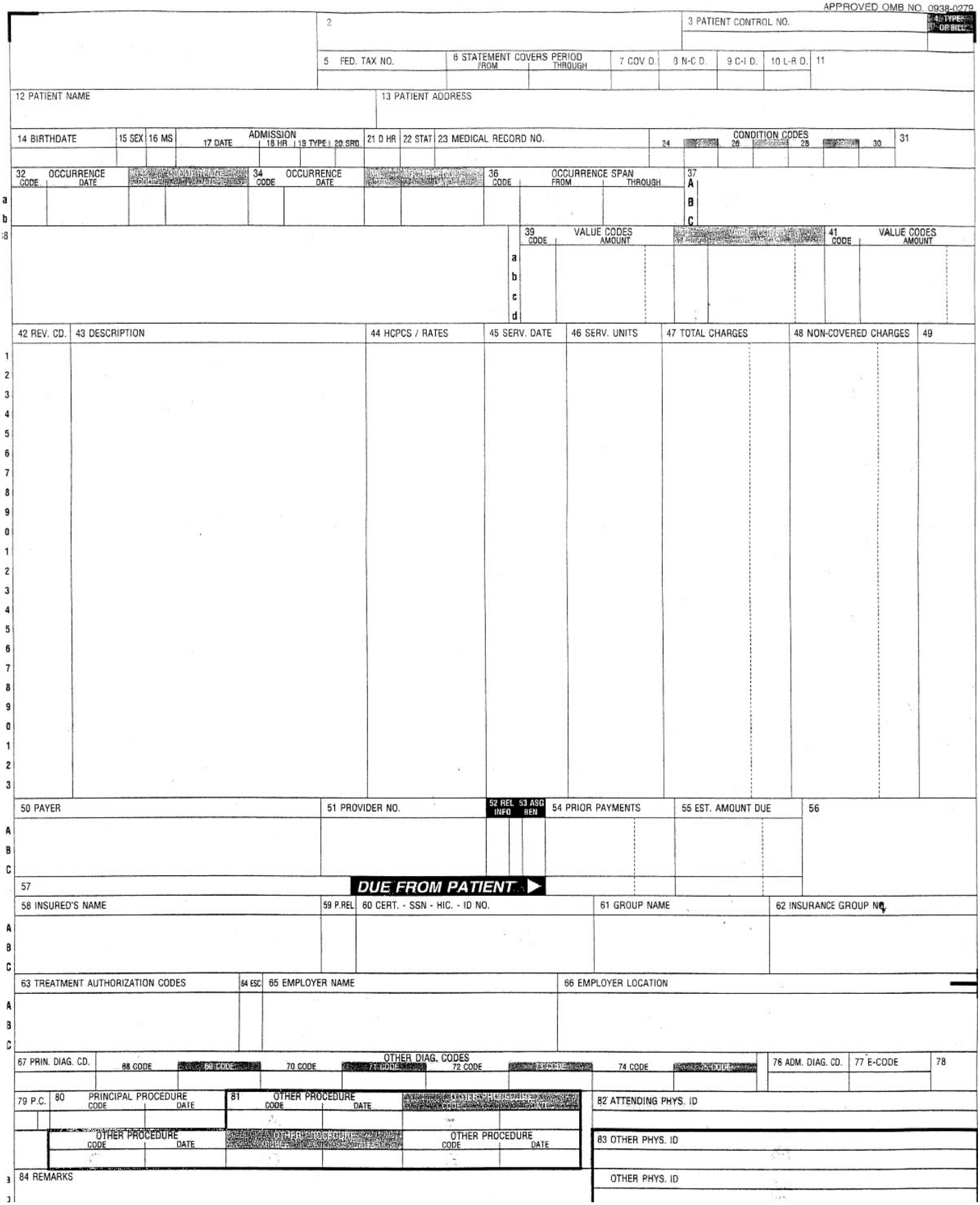
23.	Medical/Health Record Number	Enter the number that identifies the patient's medical record within the facility.
24.**- 30.**	Condition Codes	Enter the applicable two-character condition code. The values are: A1 - EPSDT/HCY. If this service is the result of an HCY referral or is an HCY related visit, enter this condition code. A4 - Family Planning. If family planning services occurred, during this visit, enter this condition code. AJ - Payer Responsible for Co-payment. If this hospital visit is the result of an emergency or therapy services are provided, then condition code must be entered to exempt the patient from the $2.00 cost sharing amount.
31.	Unlabeled Field	Leave blank.
32.** - 35.**	Occurrence Codes	If one or more of the following occurrence codes apply, enter the appropriate code(s) on the claim: 01 - Auto accident 02 - No fault insurance 03 - Accident/Tort Liability 04 - Accident/Employment Related 05 - Accident/No medical or liability coverage 06 - Crime Victim
36.	Occurrence Span	Leave blank.
37.**	Internal Control Number (Medicaid Resubmission)	For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim indicating the claim was initially submitted within the 12-month timely filing limit.
38.	Unlabeled Field	Leave blank.
39-41.	Value Codes and Amounts	Leave blank.

42.**	Revenue Code	If billing for a facility charge, an observation room charge, cardiac rehabilitation, supplies and/or on-site medications, enter only the appropriate 4-digit revenue code(s) for the hospital's outpatient facility charge(s). See Section 8 of this book for a list of valid outpatient hospital facility revenue codes.
43.	Description	Leave blank.
44.**	HCPCS/Rates	Enter the CPT or HCPCS procedure code(s) and any applicable modifier, if any, for services **other** than outpatient facility charges listed in field 42.
45.*	Service Date	Enter the date of service on each line billed in MMDDYY numeric format
46.*	Service Units	Enter the number of units for each revenue or procedure code listed. NOTE: Facility codes 0450, 0459, 0490, and 0510 should always be billed with a unit of "1". The outpatient observation code, 0762, should be billed with the appropriate unit quantity of "1", "2", "3" or "4".
47.*	Total Charges	Enter the total charge for each line item. After all charge(s) are listed, skip one line and state the total for all charges for this claim to correspond to revenue code 0001.
48.	Non-covered Charges	Leave blank.
49.	Unlabeled Field	Leave blank.
50.*	Payer	Indicate if the patient has a secondary payer by listing the name of the payer on the first line. The primary payer is always listed first; e.g., if the patient has insurance, the insurance plan is the primary payer and "Medicaid" is listed last.
51.**	Provider Number	If the Medicaid provider number was **not** entered in field 1, it must be shown here.
52.	Release of Information	Leave blank.
53.	Assignment of Benefits	Leave blank.

54.**	Prior Payments	Enter the amount received for each payer(s). Previous Medicaid payments, Medicare payments, cost sharing and co-pay amounts are not to be entered in this field. This field is required if other payer information was indicated in field 50. Payments **must** correspond with the appropriate payer entered in field 50. [See Note (1)]
55.	Estimated Amount Due	Leave blank.
56.	Unlabeled Field	Leave blank.
57.	Unlabeled Field	Leave blank.
58.**	Insured's Name	Complete if the insured's name is different from the patient's name. [See Note (1)]
59.	Patient's Relationship to Insured	Leave blank.
60.*	Certificate/SSN Number/ Health Insurance Claim/ Identification Number	Enter the patient's eight-digit Medicaid number as shown on the Medicaid ID card. If insurance was indicated in field 50, enter the insurance number to correspond with the order shown in field 50.
61.**	Group Name	If insurance is shown in field 50, state the name of the group or plan through which the insurance is provided to the insured. [See Note (1)]
62.**	Insurance Group Number	If insurance is shown in field 50, state the number assigned by the insurance company to identify the group under which the individual is covered. [See Note (1)]
63.	Treatment Authorization Code	Leave blank.
64.	Employment Status Code	Leave blank.
65.	Employer Name	Leave blank.
66.	Employer Location	Leave blank.
67.*	Principal Diagnosis Code	Enter the complete ICD 9-CM diagnosis code.

68.**- 75.**	Other Diagnosis Codes	Enter any additional ICD-9-CM diagnosis codes for which treatment was given.
76.	Admitting Diagnosis	Leave blank.
77.	E-Code	Leave blank.
78.	Unlabeled field	Leave blank.
79.	Procedure Coding Method	Leave blank.
80.**	Principal Procedure Code and Date	Enter the appropriate CPT surgical procedure code for the principle procedure. The date on which the procedure was performed **must** be shown. Only the month and day are required.
81.**	Other Procedure Codes and Dates	If more than one procedure was performed, enter the appropriate CPT surgical procedure code(s) and the date the procedure(s) was (were) performed. Only the month and day are required.
82.*	Attending Physician ID	Enter the attending physician's Missouri (or state) license number, Missouri Medicaid provider number, or UPIN number.
83.**	Other Physician ID	If applicable, enter the admitting physician's Missouri (or other state) license number, Missouri Medicaid provider number or UPIN#. If the patient's services are restricted due to administrative lock-in, enter the lock-in physician's number in this field and submit the Medical Referral Form of Restricted Recipient (PI-118 form).
84.**	Remarks	Use this field to draw attention to attachments such as operative notes, TPL denial, etc.
85.	Provider Representative	Leave blank.
86.	Date	Leave blank.

(1) NOTE: This field is for private insurance information only. If no private insurance is involved, **LEAVE IT BLANK**. If Medicare, Medicaid, employer's name or other information appears in this field, the claim will deny.


APPROVED OMB NO. 0938-0279
2
3 PATIENT CONTROL NO.
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7 COV D.
8 N-C D.
9 C-I D.
10 L-R D.
11
12 PATIENT NAME
13 PATIENT ADDRESS
14 BIRTHDATE
15 SEX
16 MS
17 DATE
ADMISSION 18 HR 19 TYPE 20 SRC
21 D HR
22 STAT
23 MEDICAL RECORD NO.
24
CONDITION CODES 26 28 30
31
32 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
36 OCCURRENCE SPAN CODE FROM THROUGH
37
39 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATES
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
50 PAYER
51 PROVIDER NO.
52 REL INFO
53 ASG BEN
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56
57
DUE FROM PATIENT
58 INSURED'S NAME
59 P.REL
60 CERT. - SSN - HIC. - ID NO.
61 GROUP NAME
62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES
64 ESC
65 EMPLOYER NAME
66 EMPLOYER LOCATION
67 PRIN. DIAG. CD.
68 CODE
69 CODE
70 CODE
OTHER DIAG. CODES
71 CODE
72 CODE
73 CODE
74 CODE
75 CODE
76 ADM. DIAG. CD.
77 E-CODE
78
79 P.C.
80 PRINCIPAL PROCEDURE CODE DATE
81 OTHER PROCEDURE CODE DATE
OTHER PROCEDURE CODE DATE
OTHER PROCEDURE CODE DATE
OTHER PROCEDURE CODE DATE
82 ATTENDING PHYS. ID
83 OTHER PHYS. ID
OTHER PHYS. ID
84 REMARKS

SECTION 8
REVENUE CODES – OUTPATIENT
HOSPITAL FACILITY

Effective for dates of service October 16, 2003 and after, outpatient hospital providers must use the appropriate covered facility revenue codes listed below. **Only the revenue codes listed below are recognized on the outpatient hospital claim. Do not list both a facility code and a CPT/HCPCS code.**

For dates of service prior to October 16, 2003, providers should continue to bill using the appropriate Missouri Medicaid-specific procedure codes/modifiers.

FACILITY CODE DESCRIPTION	PREVIOUS CODE (Dates of Svc. prior to October 16, 2003)	REPLACEMENT REVENUE CODE (Dates of Svc. October 16, 2003 and after)
Outpatient Clinical: Non-surgical	X4003	0510
Outpatient Clinical: Surgical	X4006	0490
Emergency Room: Non-surgical	X4011	0450
Emergency Room: Surgical	X4014	0459
Medical Supplies	Y7506	0270*
Surgical Supplies	Y7509	0270*
Blood/ IV Supplies	Y7507	0260, 0390
Orthopedic Supplies	Y7508	0274
On-Site Oral Medication	J7140	0250
Observation Room, 1 to 5 hours	Y3114	0762, Quantity of 1
Observation Room, 6 to 11 hours	Y3115	0762, Quantity of 2
Observation Room, 12 to 17 hours	Y3116	0762, Quantity of 3
Observation Room, 18 to 24 hours	Y3117	0762, Quantity of 4
Cardiac Rehabilitation	93797,93798	0943

* Revenue code 270 should be reported only **once** on the outpatient claim. It is to be reported for medical or surgical supplies or both combined.

NOTE – Observation room charges may be shown separately on an outpatient claim. Only one observation revenue code per date of service may be billed to Medicaid. If the provider has a patient in an observation room more than 24 hours, the charges beyond that time **must** be absorbed as an expense to the provider. These charges **cannot** be billed to Medicaid or the patient. Only one observation code can be billed per stay. If the stay spans past midnight, only one day of service is billed which is the day the patient was put in observation.

Hospital Based Dialysis Clinics

For dates of service August 1, 2004 and after, Missouri Medicaid began accepting the appropriate revenue codes for dialysis services provided in hospital based dialysis clinics.

Revenue Code	Description
0821	Hemodialysis
0831	Peritoneal Dialysis
0841	Continuous Ambulatory Peritoneal Dialysis (CAPD)
0851	Continuous Cycling Peritoneal Dialysis (CCPD)

SECTION 9
OUTPATIENT THERAPY PROCEDURES

PHYSICAL THERAPY

Physical therapy (PT) is a Medicaid covered service for patients of any age. Use CPT procedure codes in the 97000 range or Q0086 for PT evaluation. If physical therapy is provided for a recipient under 21 years of age as a result of a screening, enter code "A1" in fields 24-30 of the UB-92 claim form to indicate that it is an EPSDT/HCY service.

> NOTE: Reimbursement made to hospitals for HCY therapy services is based on that hospital's interim outpatient reimbursement percentage; however, the final outpatient settlement does not include HCY costs or charges, nor are occupational and speech therapy cost centers allowed in computing the final outpatient cost settlement. If physical therapy is provided for a patient under 21 years of age as the result of an EPSDT/HCY screening, enter code "A1" in fields 24-30 of the UB-92 form to indicate that it is an EPSDT/HCY service.

OCCUPATIONAL AND SPEECH THERAPY

Occupational therapy is covered in the outpatient hospital setting for patients age 21 and over **only** if the therapy is adaptive training for a prosthetic or orthotic device.

Under the EPSDT/HCY Program, OT is covered for recipients under 21 years of age when:

- the need is identified by an EPSDT/HCY screen; or
- there is a physician referral; or,
- the service regimen is incorporated into a plan of care.

Codes in the EPSDT/HCY OT Program are in fifteen-minute units only. Use the following procedure codes for the EPSDT/HCY Program.

97703EP	Occupational Therapy Evaluation - 15 minutes
97535EP	Occupational Therapy Treatment - 15 minutes

* Recipients with ME code 76 or 79 are not eligible for HCY services even if they are under age 21.

SPEECH/LANGUAGE THERAPY

Speech therapy is covered in the outpatient hospital setting for patients age 21 and over **only** if the therapy is adaptive training an artificial larynx.

Under the EPSDT/HCY Program, speech/language is covered for recipients under 21 years of age when:

- the need is identified by an EPSDT/HCY screen; or
- there is a physician referral; or,
- the service regimen is incorporated into a plan of care.

Codes in the EPSDT/HCY Speech/Language Program are in 15-minute units only. Use the following procedure codes for the EPSDT/HCY Program.

92506EP	Speech/Language Evaluation - 15 minutes
92507EP	Individual Speech/Language Treatment - 15 minutes
92508EP	Group Speech/Language Treatment -15 minutes

* Recipients with ME code 76 or 79 are not eligible for HCY services even if they are under age 21.

LIMITATIONS OF EPSDT/HCY THERAPY

Evaluations are limited to four hours per discipline per provider in a 12-month period. Therapy treatment services that exceed one hour and fifteen minutes (five units) in one day must have documentation attached to the claim that justifies the need for intensive therapy treatment. Claims with six or more units for occupational or speech/language therapy suspend in the claims processing system for a consultant to review the documentation. If documentation is not attached or the consultant does not approve the additional units, the total number of units is reduced to those considered medically necessary; however, the total units are not reduced to less than five units per day. Documentation includes the evaluation, the treatment plan and the physician's orders or referral.

OUTPATIENT THERAPY SERVICES EXEMPT FROM COST SHARING

Effective for dates of service October 16, 2003 and after, condition code "AJ" must be used on the outpatient claim in order to properly identify therapy services that are exempt from the cost sharing requirement. This replaces the X02 diagnosis code previously used. For dates of service prior to October 16, 2003, providers should continue to bill using the appropriate Missouri Medicaid-specific diagnosis codes.

When billing Missouri Medicaid, indicate the usual and customary charge for the service as the billed amount in the charge column. Do not deduct the recipient's cost sharing amount from the billed charge and do not show it as an amount paid or as another source payment. The claims processing system calculates the maximum allowable fee and automatically deducts the cost sharing amount, thus determining the correct payable amount.

SECTION 10
THE REMITTANCE ADVICE

Missouri Medicaid discontinued printing and mailing paper Remittance Advices (RAs) to most providers effective July 20, 2004. The remittance advices now are available via the Internet through emomed.com. There are two versions available, the 837 format and the Printable RA.

With the implementation of Internet Remittance Advice, providers can:

- Retrieve a remittance advice the Monday following the weekend Financial Cycle run (two weeks sooner than the paper version);
- View and print the RA from your desktop; and
- Download the RA into your computer system for future reference.

More information on accessing and using the printable RA is found later in this section.

When a claim is adjudicated, it is included as a line item on the next RA. Along with listing the claim, the RA lists an "Adjustment Reason Code" to explain a payment, denial or other action. The Adjustment Reason Code is from a national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payer's reimbursement for it. The RA may also list a "Remittance Remark Code" which is from the same national administrative code set that indicates either a claim-level or service-level message that cannot be expressed with a claim Adjustment Reason Code. The Adjustment Reason Codes and Remittance Remark Codes may be found on the Division of Medical Services' website, www.dss.mo.gov/dms, and clicking on the link "HIPAA related code lists".

The date on the RA is the date the final processing cycle runs. Reimbursement will be made through a mailed check or a direct bank deposit approximately two weeks after the cycle run date. (See Claims Processing Schedule at the end of Section 1.)

The RA is grouped first by paid claims and then by denied claims. Claims in each category are listed alphabetically by the patient's last name. If the patient's name and/or Departmental Client Number (DCN) are **not** on file, only the first two letters of the last name and first letter of the first name appear.

Each claim entered into the claims processing system is assigned a 13-digit Internal Control Number (ICN) assigned for identification purposes. The first two digits of an ICN indicate the type of claim.

15 – Paper claim
18 – Paper Medicare Part B Crossover
40 – Electronic Medicare Crossover

49 – Internet claim
70 – Individual Credit to an Adjustment
50 – Individual Adjustment Request
75 – Credit Mass Adjustment
55 – Mass Adjustment

The third and fourth digits indicate the year the claim was received. The fifth, sixth, and seventh digits indicate the Julian date the claim was entered into the system. In the Julian system, the days are numbered consecutively from "001" (January 01) to "365" or "366" in a leap year (December 31). The last digits of an ICN are for internal processing.

The ICN 1504277315020 is read as a paper medical claim entered in the processing system on October 04, 2004.

If a claim is denied, a new or corrected claim form **must** be submitted as corrections **cannot** be made by submitting changes on the printed RA pages.

When a claim denies for other insurance, the commercial carrier information is shown. Up to two policies can be shown.

PRINTABLE REMITTANCE ADVICE

The Printable Internet Remittance Advice is accessed at www.emomed.com. A provider must be enrolled with emomed.com in order to access the website and the printable RA. To sign-up for emomed.com and the on-line Remittance Advice option, visit the Missouri Medicaid website www.dss.mo.gov/dms and select the Provider Information "internet access" link.

On the Printable Remittance Advice page, click on the RA date you wish to view, print or save and follow your Internet browser's instructions. The RA is in the PDF file format. Your browser will open the file directly if you have Adobe Acrobat Reader installed on your computer. If you do not have this program, go to http://www.adobe.com/products/acrobat/readsetp2.html to download it to your computer.

RAs are available automatically following each financial cycle. Each RA remains available for a total of 62 days. The oldest RA drops off as the newest becomes available. Therefore, providers are encouraged to save each RA to their computer system for future reference and use.

Note: When printing an RA, it is set to page break after 70 lines per page.

If a provider did not save an RA to his/her computer and wants access to an RA that is no longer available, the provider can request the RA through the "Aged RA Request" link on the emomed.com home page.

In general, the Printable Remittance Advice is displayed as follows.

Field	Description
RECIPIENT NAME	The recipient's last name and first name. NOTE: If the recipient's name and identification number are not on file, only the first two letters of the last name and first letter of the first name appear.
MEDICAID ID	The recipient's 8-digit Medicaid Identification number.
ICN	The 13-digit number assigned to the claim for identification purposes.
SERVICE DATES FROM	The initial date of service in MMDDYY format for the claim.
SERVICE DATES TO	The final date of service in MMDDYY format for the claim.
PAT ACCT	The provider's own patient account name or number.
CLAIM: ST	This field reflects the status of the claim. Values are: 1 = Processed as Primary, 3 = Processed as Tertiary, 4 = Denied, 22 = Reversal of Previous Payment
TOT BILLED	The total claim amount submitted.
TOT PAID	The total amount Medicaid paid on the claim.
TOT OTHER	The combined totals for patient liability (surplus), recipient copay, and spenddown total withheld.
LN	The line number of the billed service.
SERVICE DATES	The date of service(s) for the specific detail line.
REV/PROC/NDC	The submitted procedure code, NDC, or revenue code for the specific detail line. Note: The revenue code will only appear in this field if a procedure code is not present.
MOD	The submitted modifier(s) for the specific detail line.
REV CODE	The submitted revenue code for the specific detail line. Note: The revenue code only appears in this field if a procedure code has also been submitted.
QTY	The units of service submitted.
BILLED AMOUNT	The submitted billed amount for the specific detail line.
ALLOWED AMOUNT	The Medicaid maximum allowed amount for the procedure.
PAID AMOUNT	The amount Medicaid paid on the claim.

PERF PROV	The Medicaid ID number for the performing provider submitted at the detail.
SUBMITTER LN ITM CNTL	The submitted line item control number.
GROUP CODE	The Claim Adjustment Group Code is a code identifying the general category of payment adjustment. Values are: CO = Contractual Obligation CR = Correction and Reversals OA = Other Adjustment PI = Payer Initiated Reductions PR = Patient responsibility
RSN	The Claim Adjustment Reason Code is the code identifying the detailed reason the adjustment was made.
AMT	The dollar amount adjusted for the corresponding reason code.
QTY	The adjustment to the submitted units of service. This field will not be printed if the value is zero.
REMARK CODES	The Code List Qualifier Code and the Health Care Remark Code (Remittance Advice Remark Codes). The Code List Qualifier Code is a code identifying a specific industry code list. Values are: HE = Claim Payment Remark Code RX = National Council for Prescription Drug Programs Reject/Payment Codes. The Health Care Remark Codes (Remittance Advice Remark Codes) are codes used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code.
CATEGORY TOTALS	Each category (i.e., paid crossover, paid medical, denied crossover, denied medical, drug, etc.) has separate totals for number of claims, billed amount, allowed amount, and paid amount.

SECTION 11
FREQUENTLY ASKED QUESTIONS

INPATIENT HOSPITAL

How does a provider submit an inpatient claim that requires a two-page claim for all the services?
If at all possible, the provider should list all the services on a single claim form. If this is not possible, the provider may bill the services on two claim forms. In field 84 on the first page of the claim, put "page 1 of 2". In field 84 of the second page, put "page 2 of 2". Staple the claims together prior to submission.

Does a provider have to submit a claim to Medicare for a patient who has exhausted his/her Medicare inpatient benefits and get a denial from Medicare before filing a claim to Medicaid?
Yes. Medicaid requires that a claim be filed to Medicare first before filing a claim to Medicaid. Once the denial has been received, a paper claim can be filed to Medicaid and a copy of the Medicare denial attached to it. The range of dates on the claim to be filed to Medicaid must fall within the range of dates on the claim filed to Medicare. The denial code description should be visible on the Medicare denial or on an attached sheet.

Do **not** put a Part A Medicare crossover sticker on the Medicaid claim. If a sticker is put on the claim, Infocrossing will return it to the provider.

Are hospitals required to keep paper copies of attachments related to physicians' inpatient services, e.g. Second Surgical Opinion Form, Sterilization Consent form, etc.?
Yes. The hospital must maintain a paper copy of these forms in the patient's permanent file.

Is the inpatient hospital per diem rate based on the date of admission or the date of service when there is a rate change?
The per diem rate is based on the date of admission.

A hospital receives certification for a patient admission and admits the patient. Later in the admission day, the patient has to be transferred to another facility which also needs certification. How is this processed and how would the services be billed?
The Medicaid *Hospital Provider Manual*, Section 13.30.B - DAY OF DISCHARGE, DEATH, OR TRANSFER states: "Missouri Medicaid reimburses a facility for the day of admission. Medicaid does not cover the day of discharge, death or transfer **unless it also is the day of admission and then it is reimbursable**. The costs for the day of discharge, death or transfer cannot be billed to the recipient."

In the example above, both facilities must obtain certification from Health Care Excel. Whichever facility submits a properly completed claim to Medicaid first should receive reimbursement. The facility that submits a claim to Medicaid second will have its claim denied as a duplicate unless a completed *Certificate of Medical Necessity* is submitted with the claim to justify the care on the same date of service. It is advisable, however, for both facilities to submit a completed *Certificate of Medical Necessity* with their claims to avoid a duplicate service denial.

A hospital wants a pre-certification for a pregnant woman for a medical condition unrelated to the pregnancy, e.g. mental health services. Should a pregnancy diagnosis code be reported?
HCE does not review most pre-certifications if the admitting or primary diagnosis code is related to pregnancy. Therefore, a diagnosis code relating to pregnancy should **not** be used as the admitting/primary diagnosis code. If the hospital stay is not related to pregnancy, it must be clear that the pregnancy is incidental to the admitting/primary diagnosis.

Are there special documentation requirements for billing for inpatient missed abortions/miscarriage services?
Missouri Medicaid does **not** cover elective abortion services.

Any claim with a diagnosis of miscarriage, or missed or spontaneous abortion, diagnosis codes 632, 634.00-634.92, 635.00-635.92, 636-636.92 and 639-639.9, must be submitted on a paper UB-92 claim form with all appropriate documentation attached. The documentation must include the operative report, an ultrasound, the pathology report, the admit and discharge summary, etc. to show that this was not an elective abortion. If no ultrasound was performed, the reason for not performing it must be clearly documented in the patient's medical record.

The above information is required also when submitting a claim with one of the following ICD-9 surgical codes: 69.02, 69.93 or 73.1.

ICD-9 surgical codes 69.01, 69.51, 69.93, 69.99, 74.91, 75.99, and 96.49 also require a completed *Certification of Medical Necessity for Abortion* form in addition to the previously noted documents.

OUTPATIENT HOSPITAL

Is a pre-certification required from Health Care Excel for outpatient services and/or surgical procedures?
No, a pre-certification is not required for outpatient services and/or surgeries.

If a hospital has an outpatient claim that requires the submission of a second page for services provided on the same date, should two separate claims be filed

or can a two-page claim be submitted with the total appearing on the second page?
In this instance, the provider should submit two separate claims and total each individual page.

When billing for an outpatient facility charge, should a CPT/HCPCS code be entered in addition to the outpatient facility revenue code?
No. Enter only the appropriate outpatient facility revenue code. Do **not** list a CPT or HCPCS code along with the facility revenue code.

Can a provider bill for two emergency room visits on the same day for the same patient?
If the second ER visit is essentially for the same reason as the first, the hospital cannot bill for it. If the second visit is for a different reason, the hospital can bill for the visit. The two visits must be billed on the same paper claim and the ER notes for each visit attached to it.

If the patient has two ER visits on the same day at two different hospitals, whichever hospital submits a claim first will be paid. The provider that bills second will have its claim denied and will have to refile a paper claim with the ER notes attached to it.

How are emergency room services billed that continue from the initial day into the following day?
If the hospital intends to submit a claim and list condition code AJ in field 24 (to exempt the patient from being responsible for the cost sharing amount), the services will have to be billed on two separate claims, one for services on the initial day and the one for the services on the following day. The AJ condition code should be listed only on the claim for first day's services.

Can a hospital bill for multiple dates of service on the same claim for either emergency room services or therapy services and use the AJ condition code to exempt the patient from the $2.00 cost sharing amount for each date of service reported on the claim?
No. Only one date of service can be reported on an outpatient hospital claim on which the AJ condition code is reported. The AJ condition code is used on the outpatient hospital claim to exempt the patient from the $2.00 cost sharing for emergency room services or outpatient therapy services (physical therapy, chemotherapy, radiation therapy, psychology/counseling and renal dialysis).

A Medicaid patient presents to the hospital emergency department for non-emergent care. Eligibility is checked and it is determined the patient is administratively locked-in to a provider. The ER department tries to contact the designated lock-in provider who either is not available or will not authorize the services through the PI-118 lock-in form. Since the ER department cannot get a referral from the lock-in provider, can these services be billed to the patient or does the hospital have to write them off?

The patient can be billed for the care. Patients who have been administratively locked-in to a designated provider know this and know who their lock-in provider is. Further, they know that if they try to obtain non-emergent services from another provider, the patient can be held responsible for the costs of the service if the treating provider is unable to obtain a referral from the lock-in provider.

How does a hospital bill for an injection for which there is no J-code?
If there is no appropriate J-code for an injection, the hospital can bill one of the following codes.

J-3490 – unclassified drug
J-7599 – immunosuppressive, not otherwise classified
J-8499 – prescription drug, oral, non-chemotherapeutic, NOS
J-8999 – oral prescription, chemotherapeutic, NOS

The injection code will have to be filed on a paper claim and an invoice **must** be attached which shows the name, the national drug code and the cost for the drug.

Can I bill for a non-payable injection under medical supplies?
No. An injection with a J-code that is not payable under Missouri Medicaid **cannot** be billed under revenue code 270 (medical supplies).

Are hospital's required to keep paper copies of attachments used for physicians' outpatient services, e.g. Second Surgical Opinion Form, Sterilization Consent form, etc.?
Yes. The hospital must maintain a copy of these forms in the patient's permanent file.

Can HCPCS "Q" codes be used to bill for Medicaid services?
HCPCS "Q" codes are national codes given by the Center for Medicare Services (CMS) on a temporary basis. In general, "Q" codes are not to be used to bill for Medicaid services and are considered non-covered.

Does Medicaid have allowable quantities that can be billed for outpatient services?
Yes. Each procedure code has an allowable quantity that can be billed to Medicaid without additional documentation. A provider can access the Medicaid fee schedules, which include allowable quantities, through the Division of Medical Services website, www.dss.mo.gov/dms.

How is a claim billed when more than the allowable quantity of a procedure was performed?
A provider cannot bill for more than the Medicaid allowable quantity on a single line on the claim. The additional quantities have to be billed on subsequent lines and the hospital's notes sent with the claim for manual review and processing. Example - the Medicaid allowable for a procedure is two but the hospital wants to bill for 5. The hospital would bill one line with the procedure code and a quantity of two, a second line

with the procedure code and a quantity of two, and a third line with the procedure code and a quantity of 1, and the hospital notes submitted with the claim.

What is the proper way to bill for a comprehensive metabolic panel, procedure code 80053?
If only CPT code 80053 was performed, bill the code without any modifiers. Providers should be aware that 80053 might be included in CPT code 80050 (general health panel) if certain other lab services are being billed for the same date of service.

CPT code 80050 includes 80053 in addition to:

> Blood count, complete (CBC), automated and automated differential WBC count (80025 or 85027 and 85004) or,
>
> Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009)
>
> Thyroid stimulating hormone (TSH) (84443)

Since procedure codes 93797 and 93798 are no longer covered, what is the correct way to bill for outpatient cardiac rehabilitation services?
For dates of service October 16, 2003 and after, providers should bill using the appropriate revenue code, 0943 - cardiac rehabilitation. Do **not** list a CPT procedure code with this revenue code. For dates of service prior to October 16, 2003, providers should use CPT codes 93797 and 93798.

Are there special documentation requirements for billing for outpatient missed abortions/miscarriage services?
Missouri Medicaid does **not** cover elective abortion services.

Any claim with a diagnosis of miscarriage, or missed or spontaneous abortion, diagnosis codes 632, 634.00-634.92, 635.00-635.92, 636-636.92 and 639-639.9, must be submitted on a paper UB-92 claim form with all appropriate documentation attached. The documentation must include the operative report, an ultrasound, the pathology report, the admit and discharge summary, etc. to show that this was not an elective abortion. If no ultrasound was performed, the reason for not performing it must be clearly documented in the patient's medical record.

The above information is required also when submitting a claim with one of the following CPT codes: 59200, 59812, 59821, or 59830.

CPT codes 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, and 59866 also require a completed *Certification of Medical Necessity for Abortion* form in addition to the previously noted documents.

SECTION 12
PATIENT COST SHARING AND CO-PAY

Patients eligible to receive certain Missouri Medicaid services are required to pay a small portion of the cost of the services. This amount is referred to as cost sharing or co-pay. The cost sharing or co-pay amount is paid by the patient at the time services are rendered. Services of the Hospital Program described in this book may be subject to a cost sharing or co-pay amount. The provider must accept in full the amounts paid by the state agency plus any cost sharing or co-pay amount required of the patient.

PROVIDER RESPONSIBILITY TO COLLECT COST SHARING AMOUNTS

Providers of service must charge and collect the cost sharing amount. Providers of service may not deny or reduce services to persons otherwise eligible for benefits solely on the basis of the patient's inability to pay the fee when charged. A patient's inability to pay a required amount, as due and charged when a service is delivered, shall in no way extinguish the patient's liability to pay the amount due.

As a basis for determining whether an individual is able to pay the charge, the provider is permitted to accept, in the absence of evidence to the contrary, the patient's statement of inability to pay at the time the charge is imposed.

The provider of service must keep a record of cost sharing amounts collected and of the cost sharing amount due but uncollected because the patient did not make payment when the service was rendered.

The cost sharing amount must not be shown on the claim form. The cost sharing amount is deducted from the allowable amount, as applicable, before reimbursement is made.

PATIENT RESPONSIBILITY TO PAY COST SHARING AMOUNTS

Unless otherwise exempted (see following information), it is the patient's responsibility to pay the required cost sharing amount due. Whether or not the patient has the ability to pay the required cost sharing amount at the time the service is furnished, the amount is a legal debt and is due and payable to the provider of service. A patient is not required to pay both a co-pay and cost sharing amount. When a co-pay amount applies, a cost sharing amount is not charged to the patient.

COST SHARING AMOUNTS

The following cost sharing amounts are applied to services:

Inpatient Hospital	$10.00 per hospital stay (applicable on date of admission and charged to the patient prior to discharge)

Outpatient Clinic or Emergency Room	$2.00 for each date of service
Physician's Services (Outpatient or Emergency Room)	$1.00 for each date of service

EXEMPTIONS TO THE COST SHARING AMOUNT

The following patients or conditions are exemptions to the patient's responsibility for the cost sharing amount:

Patients

- Patients under Age 18;
- Foster care children up to 21 years of age; (ME codes 07 and 08);
- Hospice patients;
- Institutionalized patients who are residing in a skilled nursing facility, a psychiatric hospital, a residential care facility, or an adult boarding home;
- MC+ health plan enrollees are exempt from cost sharing amounts for services provided by the health plan.

Conditions

- Services related to an Early Periodic Screening, Diagnosis and Treatment (EPSDT/HCY) service. (V20.2 diagnosis or indicator);
  NOTE: The EPSDT/HCY exemption only applies to those patients under age 18. Patients age 18 and over are subject to the cost sharing amount for EPSDT related services unless another exemption applies.
- Emergency services; (Condition Code AJ and Admission Type 1 **must** shown on the claim form);
- Drugs and services specifically identified as relating to family planning services; (Drug class or family planning indicator);
- Services provided to pregnant women which are directly related to the pregnancy or a complication of the pregnancy; (Diagnosis code)
- Emergency inpatient admission (including newborn); (Admit type)
- Transfer inpatient admission; (Admit type)
- Therapy services in an emergency room or outpatient hospital setting: (physical therapy, chemotherapy, radiation therapy, psychology/counseling and renal dialysis) (Condition code AJ **must** be shown on the out patient claim.).

PROVIDER RESPONSIBILITY TO COLLECT CO-PAY AMOUNTS

Providers of service must charge and collect the co-pay amount. Providers of service may not deny or reduce services to persons otherwise eligible for benefits solely on the basis of the patient's inability to pay the fee when charged. A patient's inability to pay a

required amount, as due and charged when a service is delivered, shall in no way extinguish the patient's liability to pay the amount due.

As a basis for determining whether an individual is able to pay the charge, the provider is permitted to accept, in the absence of evidence to the contrary, the patient's statement of inability to pay at the time the charge is imposed.

The provider of service must keep a record of co-pay amounts collected and of the co-pay amount due but uncollected because the patient did not make payment when the service was rendered.

The co-pay amount is not to be shown as an amount received on the claim form submitted for payment. When determining the reimbursement amount, the co-pay amount is deducted from the Medicaid maximum allowable amount, as applicable, before reimbursement is made.

PATIENT RESPONSIBILITY TO PAY CO-PAY AMOUNTS

It is the responsibility of the patient to pay the required co-pay amount due. Whether or not the patient has the ability to pay the required co-pay amount at the time the service is furnished, the amount is a legal debt and is due and payable to the provider of service. The co-pay only applies to identified services and patients with certain medical eligibility codes.

INPATIENT SERVICES REQUIRING A CO-PAY

Individuals with an ME code of 76 must pay a $10.00 co-pay for inpatient services. The co-pay amount applies whether the individual receives services on a fee-for-service basis or is enrolled in a health plan. The co-pay amount is deducted from the Medicaid Maximum Allowable amount for fee-for-service claims reimbursed by the Division of Medical Services. Emergency and transfer admissions and newborn services do not require a co-pay.

OUTPATIENT CLINIC SERVICES REQUIRING A CO-PAY

Individuals with an ME code of “74” must pay a $5.00 co-pay and individuals with an ME code of 75 or 76 must pay a $10.00 co-pay for identified services. The following services require a co-pay.

Procedure Codes	
97001	Physical Therapy Evaluation
97002	Physical Therapy Re-evaluation
97003EP*	Occupational Therapy Evaluation
97004EP*	Occupational Therapy Re-evaluation
92506EP*	Speech Therapy Evaluation

* NOTE: persons eligible with an ME code of 76 are not eligible to receive services under these procedure codes as these are EPSDT/HCY services

and are non-covered for low-income uninsured parents even if they are under the age of 21.

Revenue Codes

0510	Non-surgical facility charge
0490	Surgical facility charge
0450	ER-Non-surgical facility charge
0459	ER-Surgical facility charge

A facility charge cannot be billed the same day as an evaluation. Only one co-pay applies per date of service.

SECTION 13
MEDICARE CROSSOVER CLAIMS

Medicare/Medicaid (crossover) claims that do not cross automatically from Medicare to Medicaid, must now be filed through the Medicaid billing website at www.emomed.com or through the 837 electronic claim transaction. This requirement became effective July 1, 2005. Before filing an electronic crossover claim, please wait sixty (60) days from the date of your Medicare payment to avoid possible duplicate payments from Medicaid.

The major reason that claims do not cross over electronically from Medicare to Medicaid is because Medicaid enrolled providers have not provided Medicaid with their Medicare provider number or have provided an invalid or inactive Medicare provider number. If the hospital provider has a Medicare Part A or Medicare Part B number or both, then the Medicare number(s) must be on the Medicaid provider master file in order for the claims to electronically cross over from Medicare to Medicaid.

If the provider has any doubt as to what Medicare number(s) is (are) on file for the provider, contact the Provider Enrollment Unit by e-mail at ProviderEnrollment@dss.mo.gov. If you have not submitted your provider number to Medicaid, you can fax a copy of the Medicare letter showing the Medicare provider name and Medicare number assigned along with a cover letter explaining why the information is being submitted to the enrollment unit. The unit's fax number is 573/526-2054.

Following are tips to assist you in successfully filing a claim at the Medicaid billing website:

- At the Medicaid billing website at www.emomed.com, choose the same crossover claim form that you completed to bill Medicare. For hospital Part A claims, select "Medicare UB-92 Part A Crossover." For hospital part B of A, select "Medicare UB-92 Part B of A Crossover." Be sure you select the correct provider number from the drop down box in the upper right hand corner of the first claims screen.
- Enter the information in the fields on the screen exactly as you did on your Medicare billing except that you should enter the patient's name as it appears on the Medicaid card and **not** the name that is shown on the Medicare remittance advice.
- There are HELP screens at the bottom of each screen page to provide instructions for completing the crossover claim screens, the "Other Payer" header and the "Other Payer" detail screens. Print each HELP screen in its entirety for reference when completing claims on the Internet.
- There must be an "Other Payer" header screen completed for every crossover claim type. This provides information that pertains to the whole claim.
- For Part A claims, the provider **must** complete both the revenue code and the days or units billed fields at the line level. No other information is required at the line level.

- Part B of A claims need the “Other Payer” header form completed without group code, reason code and adjustment amount information. Completion of an “Other Payer” detail screen form is required for each claim detail line.
- The five (5) codes that can be entered in the "Group Code" field on the "Other Payer" Header and Detail screen forms are in a drop down box and you should choose the appropriate code. For example, the "PR" code (patient responsibility) is understood to be the code assigned for deductible and/or coinsurance amounts shown on your Medicare EOMB.
- The codes to enter in the "Reason Code" field on the "Other Payer" Header and Detail screen forms are found on your Medicare EOMB. If not listed there, you must choose the most appropriate code from the list of "Claim Adjustment Reason Codes" which can be found in the HIPAA Related Code List under the Quick Links at http://www.dss.mo.gov/dms. For example, the code shown on the "Claim Adjustment Reason Codes" list for "deductible amount" is 1 and for "coinsurance amount" is 2. Therefore, you would enter a "Reason Code" of "001" for deductible amounts due and a "Reason Code" of "002" for coinsurance amounts due.
- The "Adjust Amount" should reflect any amount not paid by Medicare including deductible, coinsurance, and any non-allowed amounts.
- If there is a commercial insurance payment or denial to report on the crossover claim, you must complete an additional "Other Payer" Header form. You must also complete an additional "Other Payer" Detail form(s) if the commercial carrier provided detail line information for line payments and denials.

Samples of Part A (inpatient hospital) and Part B of A (outpatient hospital) claims are displayed on the following pages.

SAMPLE - MEDICARE HOSPITAL REMITTANCE ADVICE

PART A INPATIENT (NO TPL)

MEDICARE NATIONAL STANDARD INTERMEDIARY REMITTANCE ADVICE

FPE: 06/30/2005 Mutual of Omaha
PAID: 04/22/2005
CLM# : 22
TOB: 111

26XXXX

PATIENT SHRIEK WILL PCN: 327XXXXX
HIC: 400-00-0000A SVC FROM: 01/31/2005 MRN: 111100
PAT STAT: CLAIM STAT: 1 THRU: 02/09/2005 ICN: 20517900129999 02

CHARGES:
33997.41 = REPORTED
0.00 = NCVD/DENIED
23825.59 = CLAIM ADJS
33997.41 = COVERED

DAYS/VISITS:
9 = COST REPT
0 = COVD/UTIL
0 = NON-COVERED
0 = COVD VISITS
0 = NCOV VISITS

PAYMENT DATA: 315 = DRG
10171.82 = DRG AMOUNT
893.25 = DRG/OPER/CAP
0.00 = LINE ADJ AMT
0.00 = OUTLIER
0.00 = CAP OUTLIER
912.00 = CASH DEDUCT
0.00 = BLOOD DEDUCT
0.00 = COINSURANCE
0.00 = PAT REFUND
0.00 = MSP LIAB MET

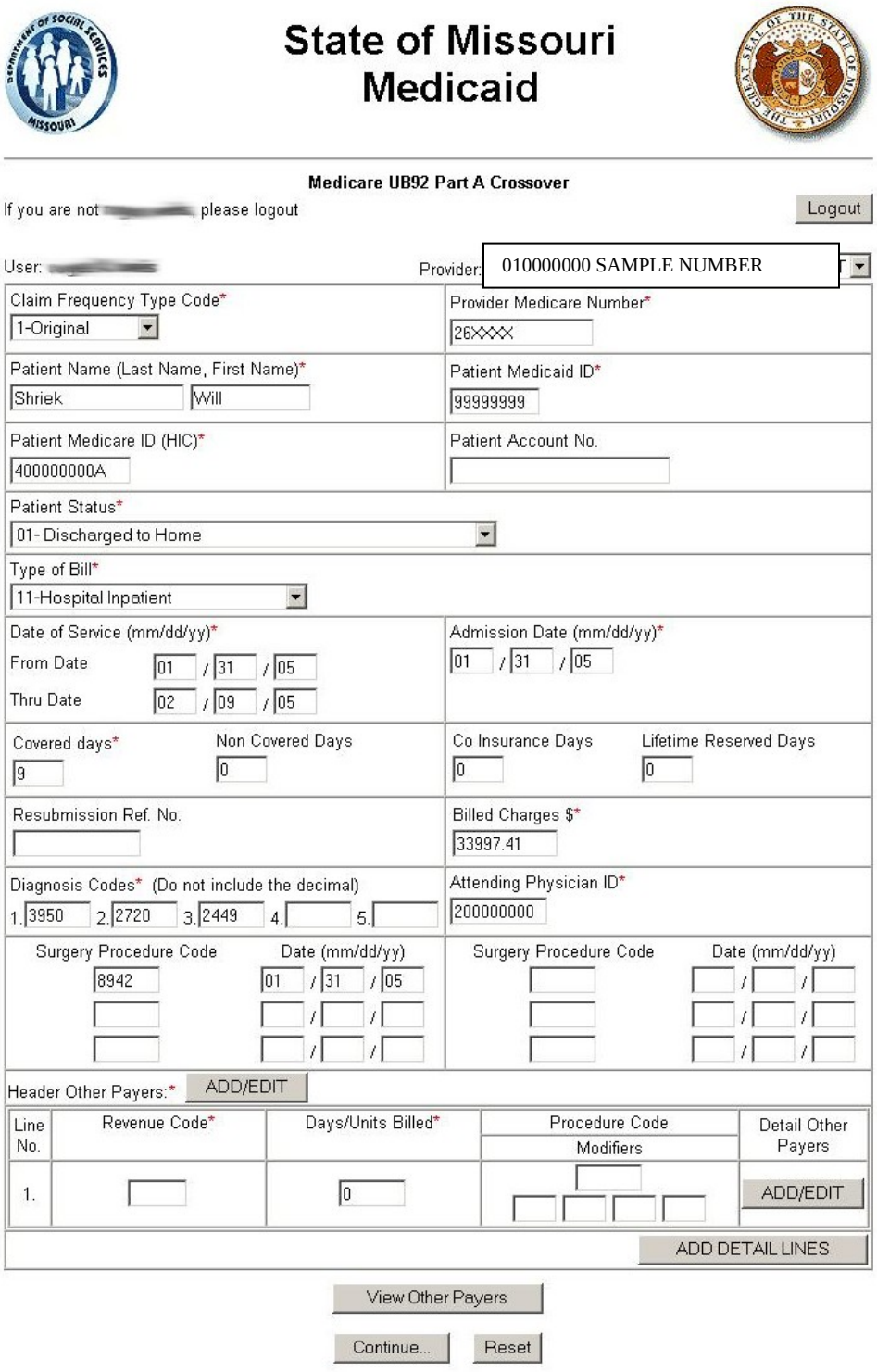
0.000 = REIM RATE
0.00 = MSP PRIM PAYER
0.00 = PROF COMPONENT
0.00 = ESRD AMOUNT
0.00 = PROC CD AMOUNT
33997.41 = ALLOW/REIM
0.00 = G/R AMOUNT
0.00 = INTEREST
0.00 = CONTRACT ADJ
0.00 = PER DIEM AMT
9259.82 = NET REIM AMT

ADJ REASON CODES: CO 94 23825.59
PR 1 912

REMARK CODES MA02

REV	DATE	HCPCS	APC/HIPPS	MODS	QTY	CHARGES	ALLOW/REIM	GC	RSN	AMOUNT	REMARK	CODES
0120	02/09				7	4760.00	4760.00					
0200	02/09				2	3244.00	3244.00					
0250	02/09				234	1238.00	1238.00					
0255	02/09				1	67.00	67.00					
0258	02/09				12	500.00	500.00					
0270	02/09				50	4468.41	4468.41					
0278	02/09				1	3352.00	3352.00					
0300	02/09				8	80.00	80.00					
0301	02/09				20	1718.00	1718.00					
0305	02/09				8	400.00	400.00					
0306	02/09				1	98.00	98.00					
0307	02/09				2	84.00	84.00					
0320	02/09				1	1443.00	1443.00					
0323	02/09				1	1733.00	1733.00					
0324	02/09				2	341.00	341.00					
0351	02/09				2	2201.00	2201.00					
0361	02/09				3	6087.00	6087.00					
0410	02/09				20	1378.00	1378.00					
0420	02/09				2	120.00	120.00					
0424	02/09				1	174.00	174.00					
0921	02/09				1	511.00	511.00					

Using this example of a Medicare EOMB, the following pages will guide you step-by-step through the process to file your Crossover Claim through the Medicaid billing Website at www.emomed.com to collect the deductible/coinsurance amount.



State of Missouri Medicaid

Medicare UB92 Part A Crossover

If you are not [redacted], please logout — Logout

User: [redacted] Provider: 010000000 SAMPLE NUMBER

Claim Frequency Type Code*: 1-Original	Provider Medicare Number*: 26XXXX
Patient Name (Last Name, First Name)*: Shriek, Will	Patient Medicaid ID*: 99999999
Patient Medicare ID (HIC)*: 400000000A	Patient Account No.:
Patient Status*: 01- Discharged to Home	
Type of Bill*: 11-Hospital Inpatient	
Date of Service (mm/dd/yy)*: From Date 01/31/05, Thru Date 02/09/05	Admission Date (mm/dd/yy)*: 01/31/05
Covered days*: 9; Non Covered Days: 0	Co Insurance Days: 0; Lifetime Reserved Days: 0
Resubmission Ref. No.:	Billed Charges $*: 33997.41
Diagnosis Codes* (Do not include the decimal): 1. 3950 2. 2720 3. 2449 4. 5.	Attending Physician ID*: 200000000

Surgery Procedure Code	Date (mm/dd/yy)	Surgery Procedure Code	Date (mm/dd/yy)
8942	01/31/05		

Header Other Payers:* ADD/EDIT

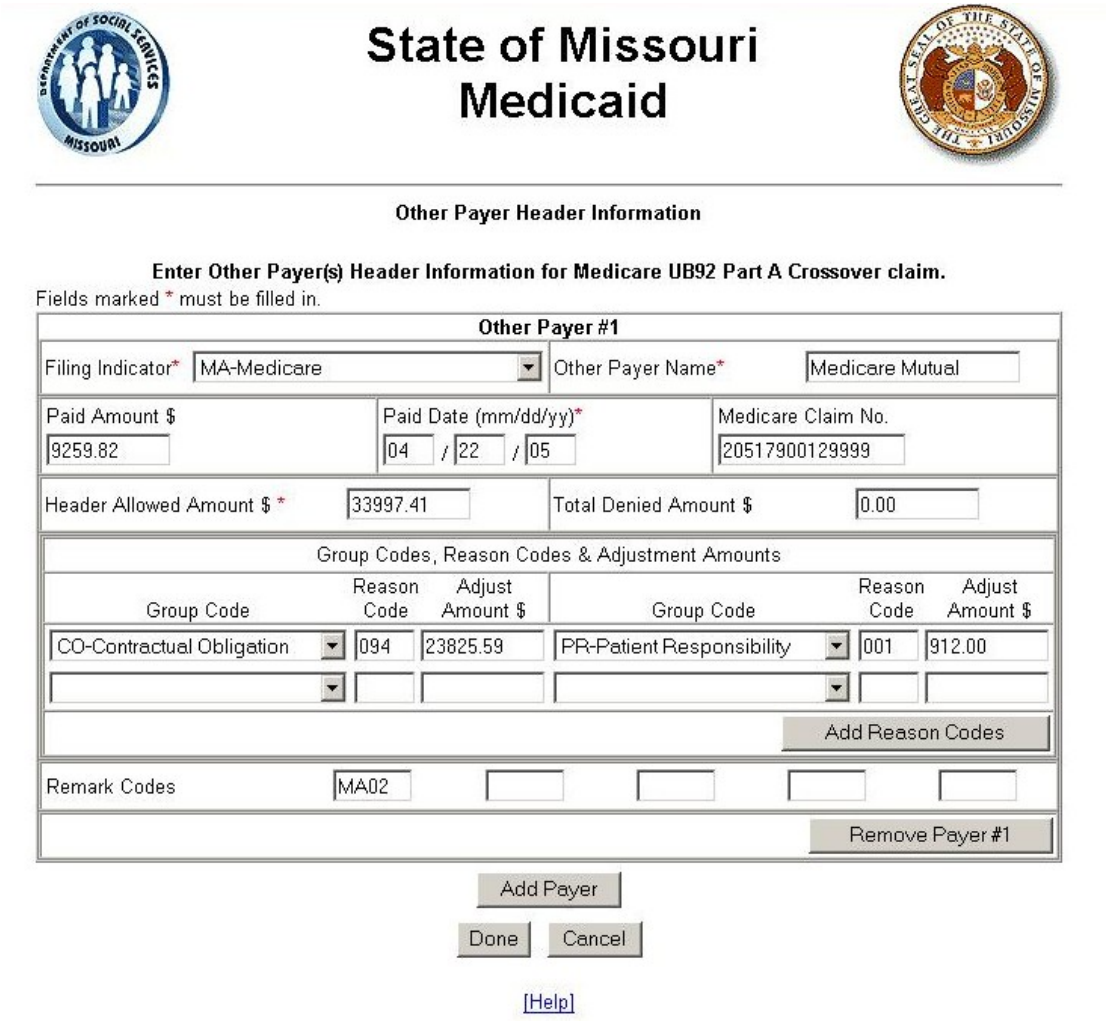
Line No.	Revenue Code*	Days/Units Billed*	Procedure Code / Modifiers	Detail Other Payers
1.		0		ADD/EDIT

ADD DETAIL LINES

View Other Payers

Continue... Reset

- **At the Medicaid billing website, click on 'Medicare UB92 Part A Crossover'. This brings you to the screen above.**
- **Scroll to the bottom of the form and click on the 'Help' button, print off and save the instructions.**
- **Scroll back to the top of the form and complete all the Medicaid header information. Refer to the Medicare EOMB on the previous page as well as the patient's medical record. Complete the fields as shown above, then complete the Header Other Payer by clicking on 'ADD/EDIT'.**



State of Missouri
Medicaid

Other Payer Header Information

Enter Other Payer(s) Header Information for Medicare UB92 Part A Crossover claim.

Fields marked * must be filled in.

Other Payer #1

Filing Indicator*	MA-Medicare	Other Payer Name*	Medicare Mutual
Paid Amount $	9259.82	Paid Date (mm/dd/yy)*	04 / 22 / 05
Medicare Claim No.	20517900129999		
Header Allowed Amount $ *	33997.41	Total Denied Amount $	0.00

Group Codes, Reason Codes & Adjustment Amounts

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO-Contractual Obligation	094	23825.59	PR-Patient Responsibility	001	912.00

Add Reason Codes

Remark Codes	MA02				

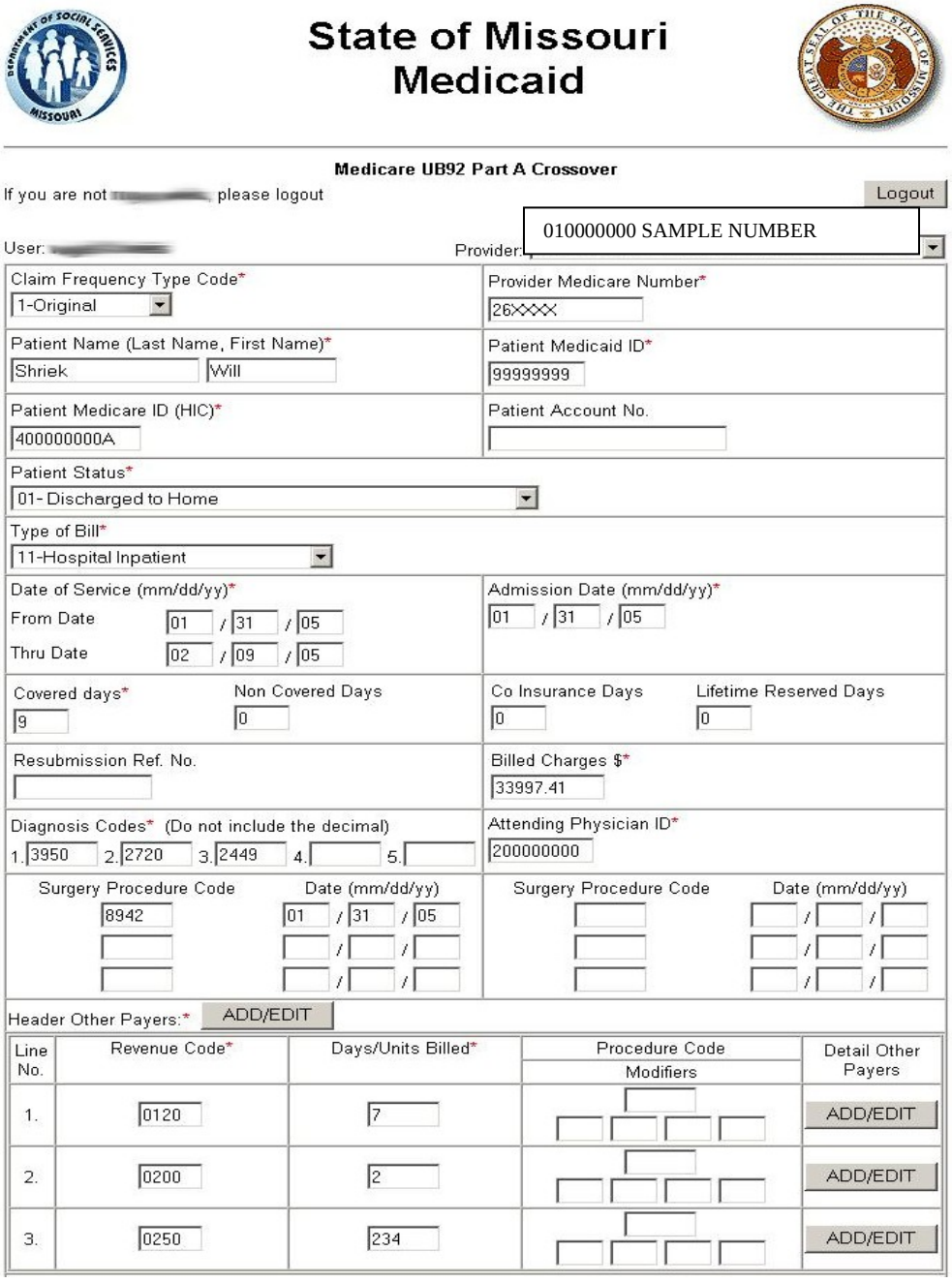
Remove Payer #1

Add Payer

Done Cancel

[Help]

- **Now you are on the Other Payer Header screen. Scroll to the bottom of the form and click on the 'Help' button, print off and save the instructions.**
- **Scroll back to the top of the form and complete the information at the top as well as the information under Group Codes, Reason Codes and Adjustment Amounts. The codes and amounts will usually be shown on your Medicare EOMB.**
- **After entering the information, click on 'Done'.**



State of Missouri Medicaid

Medicare UB92 Part A Crossover

If you are not [redacted], please logout — Logout

010000000 SAMPLE NUMBER

User: [redacted] Provider:

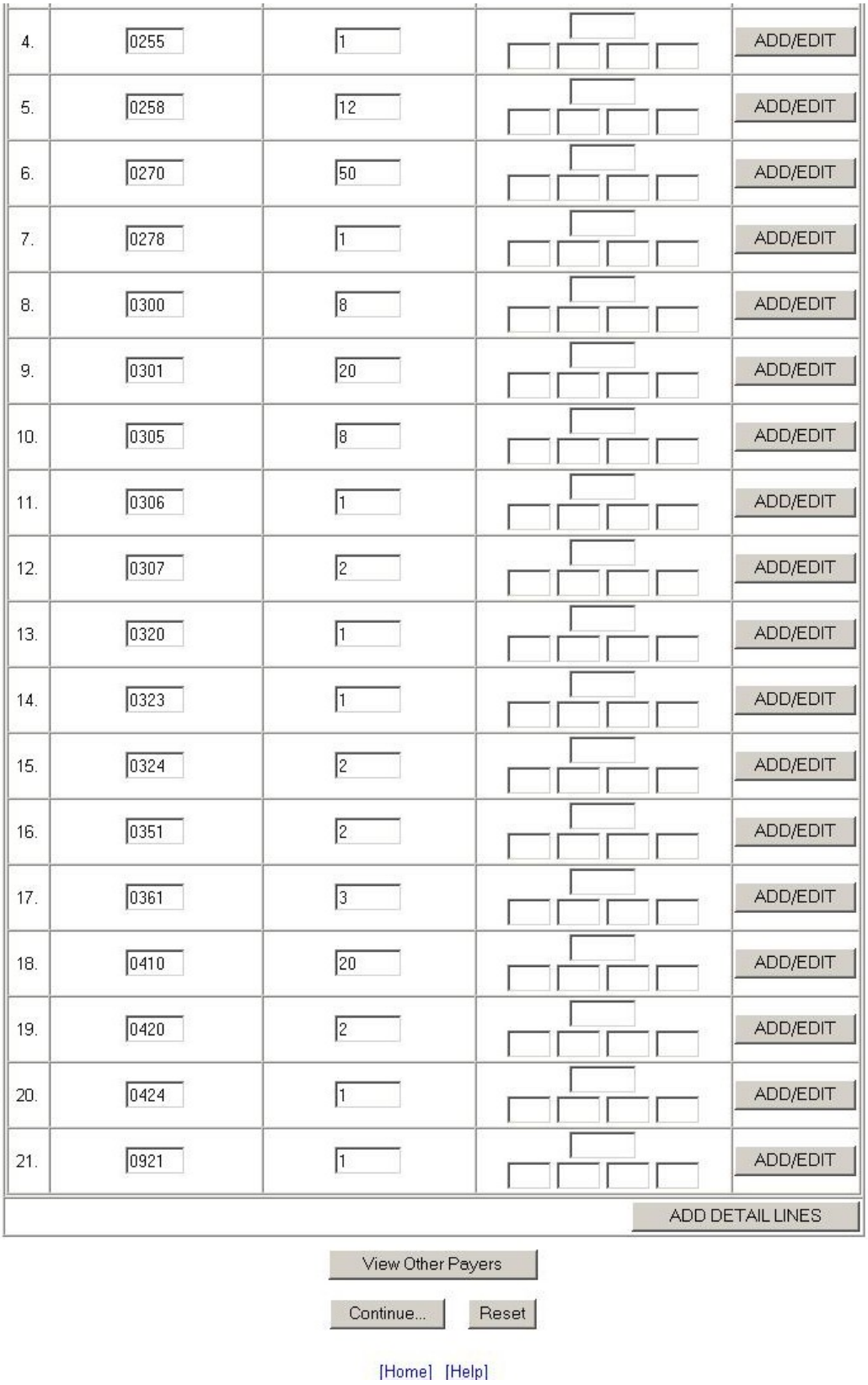
Claim Frequency Type Code*: 1-Original	Provider Medicare Number*: 26XXXX
Patient Name (Last Name, First Name)*: Shriek, Will	Patient Medicaid ID*: 99999999
Patient Medicare ID (HIC)*: 400000000A	Patient Account No.:
Patient Status*: 01- Discharged to Home	
Type of Bill*: 11-Hospital Inpatient	
Date of Service (mm/dd/yy)*: From Date 01/31/05, Thru Date 02/09/05	Admission Date (mm/dd/yy)*: 01/31/05
Covered days*: 9; Non Covered Days: 0	Co Insurance Days: 0; Lifetime Reserved Days: 0
Resubmission Ref. No.:	Billed Charges $*: 33997.41
Diagnosis Codes* (Do not include the decimal): 1. 3950 2. 2720 3. 2449 4. 5.	Attending Physician ID*: 200000000

Surgery Procedure Code	Date (mm/dd/yy)	Surgery Procedure Code	Date (mm/dd/yy)
8942	01/31/05		

Header Other Payers:* ADD/EDIT

Line No.	Revenue Code*	Days/Units Billed*	Procedure Code / Modifiers	Detail Other Payers
1.	0120	7		ADD/EDIT
2.	0200	2		ADD/EDIT
3.	0250	234		ADD/EDIT

- **Now you are back on the original starting screen ready to add your detail information to the claim.**
- **Again, using the Medicare EOMB example from the previous page, enter the detail information as shown above on the next page. Click the 'ADD DETAIL LINES' until you have all detail lines entered.**
- **Note- This screen print is continued on page 5.**
- **On Medicare Part A crossovers, it is not necessary to add the Medicare Other Payer detail information. At this point, you are done entering the information. Click on 'Continue'.**



4.	0255	1		ADD/EDIT
5.	0258	12		ADD/EDIT
6.	0270	50		ADD/EDIT
7.	0278	1		ADD/EDIT
8.	0300	8		ADD/EDIT
9.	0301	20		ADD/EDIT
10.	0305	8		ADD/EDIT
11.	0306	1		ADD/EDIT
12.	0307	2		ADD/EDIT
13.	0320	1		ADD/EDIT
14.	0323	1		ADD/EDIT
15.	0324	2		ADD/EDIT
16.	0351	2		ADD/EDIT
17.	0361	3		ADD/EDIT
18.	0410	20		ADD/EDIT
19.	0420	2		ADD/EDIT
20.	0424	1		ADD/EDIT
21.	0921	1		ADD/EDIT

State of Missouri Medicaid

Medicare UB92 Part A Crossover

If you are not [redacted], please logout Logout

User: [redacted] Provider: [redacted] 010000000 SAMPLE NUMBER

Please verify the values entered and click the Edit or Submit button.

Claim Frequency Type Code 1	**Provider Medicare Number** 26XXXX
Patient Name (Last Name, First Name) Shriek, Will	**Patient Medicaid ID** 99999999
Patient Medicare ID (HIC) 40000000A	**Patient Account No.**
Patient Status 01	**Type of Bill** 11
Date of Service (mm/dd/yy) **From Date** 01/31/05 **Thru Date** 02/09/05	**Admission Date (mm/dd/yy)** 01/31/05
Covered days 9 **Non Covered Days** 0	**Co Insurance Days** 0 **Lifetime Reserved Days** 0
Resubmission Ref. No.	**Billed Charges $** 33,997.41
Diagnosis Codes 3950 2720 2449	**Attending Physician ID** 200000000
Surgery Procedure Code 8842 **Date (mm/dd/yy)** 01/31/05	**Surgery Procedure Code** **Date (mm/dd/yy)**

Header Other Payers: *Click 'View Other Payers'*

Line No.	Revenue Code	Days/Units Billed	Procedure Code / Modifiers	Detail Other Payers
1.	0120	7		*Click 'View Other Payers'*
2.	0200	2		*Click 'View Other Payers'*
3.	0250	234		*Click 'View Other Payers'*
4.	0255	1		*Click 'View Other Payers'*
5.	0258	12		*Click 'View Other Payers'*

- **This brings you back to a 'verify' screen asking you to review the information and then either edit the information or submit the claim.**
- **Note- This screen print is continued on page 7.**
- **Click on 'Submit'.**

6.	0270	50		Click 'View Other Payers'
7.	0278	1		Click 'View Other Payers'
8.	0300	8		Click 'View Other Payers'
9.	0301	20		Click 'View Other Payers'
10.	0305	8		Click 'View Other Payers'
11.	0306	1		Click 'View Other Payers'
12.	0307	2		Click 'View Other Payers'
13.	0320	1		Click 'View Other Payers'
14.	0323	1		Click 'View Other Payers'
15.	0324	2		Click 'View Other Payers'
16.	0351	2		Click 'View Other Payers'
17.	0361	3		Click 'View Other Payers'
18.	0410	20		Click 'View Other Payers'
19.	0420	2		Click 'View Other Payers'
20.	0424	1		Click 'View Other Payers'
21.	0921	1		Click 'View Other Payers'

View Other Payers

Edit Submit

[Home] [Help]

State of Missouri Medicaid

Medicare UB92 Part A Crossover

If you are not [redacted] please logout Logout

User: [redacted] Provider: 010000000 SAMPLE NUMBER

Thank you. Your claim has been received.

Claim Frequency Type Code 1	**Provider Medicare Number** 26XXXX
Patient Name (Last Name, First Name) Shriek, Will	**Patient Medicaid ID** 99999999
Patient Medicare ID (HIC) 40000000A	**Patient Account No.**
Patient Status 01	**Type of Bill** 11
Date of Service (mm/dd/yy) **From Date** 01/31/05 **Thru Date** 02/09/05	**Admission Date (mm/dd/yy)** 01/31/05
Covered days 9 **Non Covered Days** 0	**Co Insurance Days** 0 **Lifetime Reserved Days** 0
Resubmission Ref. No.	**Billed Charges $** 33,997.41
Diagnosis Codes 3950 2720 2449	**Attending Physician ID** 200000000
Surgery Procedure Code 8842 **Date (mm/dd/yy)** 01/31/05	**Surgery Procedure Code** **Date (mm/dd/yy)**

Header Other Payers: *Click 'View Other Payers'*

Line No.	Revenue Code	Days/Units Billed	Procedure Code / Modifiers	Detail Other Payers
1.	0120	7		*Click 'View Other Payers'*
2.	0200	2		*Click 'View Other Payers'*
3.	0250	234		*Click 'View Other Payers'*
4.	0255	1		*Click 'View Other Payers'*
5.	0258	12		*Click 'View Other Payers'*

- **After submitting your claim, you will be brought to a screen which states, "Thank you. Your claim has been received". Click on the 'Print' button at the bottom of the screen to print off and save for your records.**
- **Note – This screen print is continued on page 9.**
- **To enter another claim, click on 'Next'.**

6.	0270	50		Click 'View Other Payers'
7.	0278	1		Click 'View Other Payers'
8.	0300	8		Click 'View Other Payers'
9.	0301	20		Click 'View Other Payers'
10.	0305	8		Click 'View Other Payers'
11.	0306	1		Click 'View Other Payers'
12.	0307	2		Click 'View Other Payers'
13.	0320	1		Click 'View Other Payers'
14.	0323	1		Click 'View Other Payers'
15.	0324	2		Click 'View Other Payers'
16.	0351	2		Click 'View Other Payers'
17.	0361	3		Click 'View Other Payers'
18.	0410	20		Click 'View Other Payers'
19.	0420	2		Click 'View Other Payers'
20.	0424	1		Click 'View Other Payers'
21.	0921	1		Click 'View Other Payers'

View Other Payers

Next Print

[Home] [Help]

SAMPLE - MEDICARE REMITTANCE

PART B OF A - OUT PATIENT HOSPITAL (NO TPL)

Medicare National Standard Intermediary Remittance Advice

FPE: 06/30/2005

PAID: 10/14/2004

CLM# : 203

53XX X TOB: 131

PATIENT: SHRIEK WILL PCN: 000X1

HIC: 400-00-0000A SVC FROM: 09/07/2004 MRN: Z111111

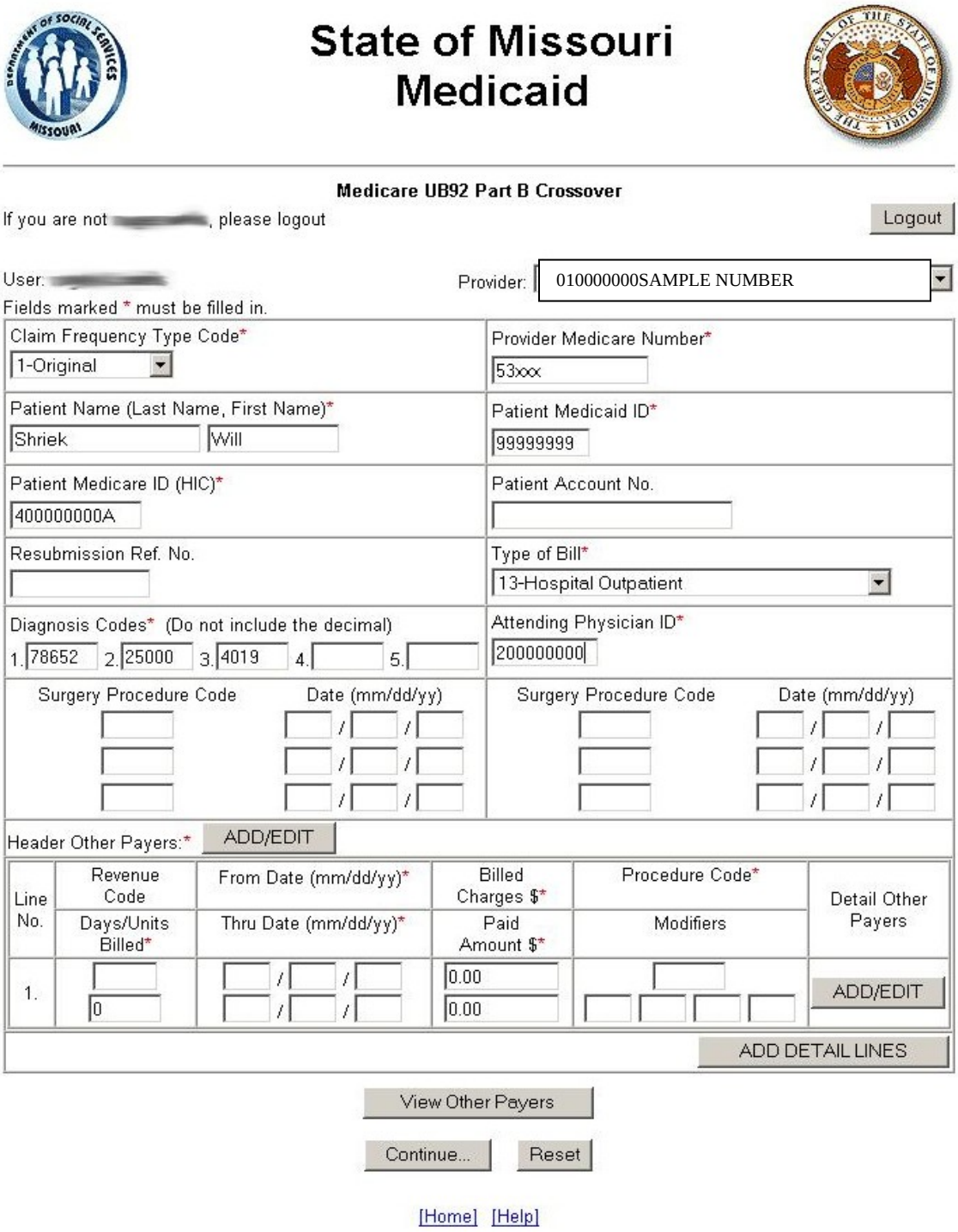
PAT STAT: CLAIM STAT: 1 THRU: 09/07/2004 ICN: 2042670099999

CHARGES:	PAYMENT DATA: =DRG	0.550=REIM RATE
2102.00=REPORTED	0.00=DRG AMOUNT	0.00=MSP PRIM PAYER
0.00=NCVD/DENIED	0.00=DRG/OPER/CAP	0.00=PROF COMPONENT
0.00=CLAIM ADJS.	1508.11=LINE ADJ-AMT	0.00=ESRD AMOUNT
2102.00=COVERED	0.00=OUTLIER	76.65=PROC CD AMOUNT
DAYS/VISITS:	0.00=CAP OUTLIER	397.94=ALLOW/REIM
0=COST REPT	0.00=CASH DEDUCT	0.00=G/R AMOUNT
0=COVD/UTIL	0.00=BLOOD DEDUCT	0.00=INTEREST
0=NON-COVERED	195.95=COINSURANCE	0.00=CONTRACT ADJ
0=COVD VISITS	0.00=PAT REFUND	0.55=PER DIEM AMT
0=NCOV VISITS	0.00=MSP LIAB MET	397.94=NET REIM AMT

REMARK CODES: MA01

REV	DATE	BCPCS	APC/HIPPS	MODS	QTY.	CHARGES	ALLOW/RETH	GC	RSN	AMOUNT	REMARK CODES
0255	09/07				1	99.00	0.00	CO	97	99.00	
0270	09/07				12	191.00	0.00	CO	97	191.00	
0300	09/07	80053			1	45.00	9.44	CO	42	35.56	
0300	09/07	82550			1	28.00	5.82	CO	42	22.18	
0300	09/07	82553			1	106.00	16.67	CO	42	89.33	
0300	09/07	84484			1	112.00	9.66	CO	42	102.34	
0300	09/07	85025			1	69.00	11.22	CO	42	57.78	
0300	09/07	85379			1	104.00	10.59	CO	42	93.41	
0300	09/07	85610			1	20.00	4.59	CO	42	15.41	
0300	09/07	85730			1	36.00	8.66	CO	42	27.34	
0320	09/07	71010	00260		1	128.00	20.28	CO	45	87.45	
								PR	2	20.27	
0350	09/07	71260	00283		1	809.00	121.61	CO	45	567.11	
								PR	2	120.28	
0450	09/07	99284	00612	25	1	302.00	164.01	CO	45	86.44	
								PR	2	51.55	
0730	09/07	93005	00099		1	53.00	15.39	CO	45	33.76	
								PR	2	3.85	

- **Using the example of a Medicare EOMB, the following pages will guide you step-by-step through the process to file your Crossover Claim through the Medicaid billing Website at www.emomed.com to collect the deductible/coinsurance amount.**



State of Missouri Medicaid

Medicare UB92 Part B Crossover

If you are not [redacted], please logout — Logout

User: [redacted] Provider: 010000000SAMPLE NUMBER

Fields marked * must be filled in.

Claim Frequency Type Code*: 1-Original	Provider Medicare Number*: 53xxx
Patient Name (Last Name, First Name)*: Shriek, Will	Patient Medicaid ID*: 99999999
Patient Medicare ID (HIC)*: 400000000A	Patient Account No.:
Resubmission Ref. No.:	Type of Bill*: 13-Hospital Outpatient
Diagnosis Codes* (Do not include the decimal): 1. 78652 2. 25000 3. 4019 4. 5.	Attending Physician ID*: 200000000

Surgery Procedure Code	Date (mm/dd/yy)	Surgery Procedure Code	Date (mm/dd/yy)
	/ /		/ /
	/ /		/ /
	/ /		/ /

Header Other Payers:* ADD/EDIT

Line No.	Revenue Code / Days/Units Billed*	From Date (mm/dd/yy)* / Thru Date (mm/dd/yy)*	Billed Charges $* / Paid Amount $*	Procedure Code* / Modifiers	Detail Other Payers
1.	/ 0	/ / / /	0.00 / 0.00	/	ADD/EDIT

ADD DETAIL LINES

View Other Payers

Continue... Reset

[Home] [Help]

- **At the Medicaid billing website, click on 'Medicare UB-92 Part B of A Crossover';**
- **Scroll to the bottom of the form and click on the 'Help' button, print off and save the instructions;**
- **Scroll back to the top of the form and complete all the Medicaid header information. Refer to the Medicare EOMB on the previous page as well as the patient's medical record. Complete the fields as shown above, then complete the Header Other Payer by clicking on 'ADD/EDIT'.**

State of Missouri Medicaid

Other Payer Header Information

Enter Other Payer(s) Header Information for Medicare UB92 Part B Crossover claim.

Fields marked * must be filled in.

Other Payer #1

Filing Indicator*	MB-Medicare	Other Payer Name*	Medicare
Paid Amount $	397.94	Paid Date (mm/dd/yy)*	10 / 14 / 04
Medicare Claim No.	2042670099999		
Header Allowed Amount $ *	397.94	Total Denied Amount $	0.00

Group Codes, Reason Codes & Adjustment Amounts

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $

Add Reason Codes

Remark Codes

Remove Payer #1

Add Payer

Done Cancel

[Help]

- **Now you are on the Other Payer Header screen. Scroll to the bottom of the form and click on the 'Help' button, print off and save the instructions.**
- **Scroll back to the top of the form and complete the information at the top as shown. For Part B and Part B of A crossover claims, you do not complete the Group Codes, Reason Codes and Adjustment Amounts information. You will be entering this information elsewhere.**
- **Click on 'Done'.**

State of Missouri Medicaid

Medicare UB92 Part B Crossover

If you are not [redacted] please logout — Logout

User: [redacted] Provider: 010000000 SAMPLE NUMBER

Fields marked * must be filled in.

Claim Frequency Type Code*: 1-Original	Provider Medicare Number*: 53xxx
Patient Name (Last Name, First Name)*: Shriek, Will	Patient Medicaid ID*: 99999999
Patient Medicare ID (HIC)*: 400000000A	Patient Account No.:
Resubmission Ref. No.:	Type of Bill*: 13-Hospital Outpatient
Diagnosis Codes* (Do not include the decimal): 1. 78652 2. 25000 3. 4019 4. 5.	Attending Physician ID*: 200000000

Surgery Procedure Code	Date (mm/dd/yy)	Surgery Procedure Code	Date (mm/dd/yy)
	/ /		/ /
	/ /		/ /
	/ /		/ /

Header Other Payers:* ADD/EDIT

Line No.	Revenue Code / Days/Units Billed*	From Date (mm/dd/yy)* / Thru Date (mm/dd/yy)*	Billed Charges $* / Paid Amount $*	Procedure Code* / Modifiers	Detail Other Payers
1.	0255 / 1	09/07/04 / 09/07/04	99.00 / 0.00	00000	ADD/EDIT
2.	0270 / 12	09/07/04 / 09/07/04	191.00 / 0.00	00000	ADD/EDIT
3.	0300 / 1	09/07/04 / 09/07/04	45.00 / 9.44	80053	ADD/EDIT
4.	0300 / 1	09/07/04 / 09/07/04	28.00 / 5.82	82550	ADD/EDIT
5.	0300 / 1	09/07/04 / 09/07/04	106.00 / 16.67	82553	ADD/EDIT

➢ **See Page 5 for instructions.**

6.	0300 1	09 / 07 / 04 09 / 07 / 04	112.00 9.66	84484	ADD/EDIT
7.	0300 1	09 / 07 / 04 09 / 07 / 04	69.00 11.22	85025	ADD/EDIT
8.	0300 1	09 / 07 / 04 09 / 07 / 04	104.00 10.59	85379	ADD/EDIT
9.	0300 1	09 / 07 / 04 09 / 07 / 04	20.00 4.59	85610	ADD/EDIT
10.	0300 1	09 / 07 / 04 09 / 07 / 04	36.00 8.66	85730	ADD/EDIT
11.	0320 1	09 / 07 / 04 09 / 07 / 04	128.00 20.28	71010	ADD/EDIT
12.	0350 1	09 / 07 / 04 09 / 07 / 04	809.00 121.61	71260	ADD/EDIT
13.	0450 1	09 / 07 / 04 09 / 07 / 04	302.00 164.01	99284 25	ADD/EDIT
14.	0730 1	09 / 07 / 04 09 / 07 / 04	53.00 15.39	93005	ADD/EDIT
					ADD DETAIL LINES

View Other Payers

Continue... Reset

[Home] [Help]

- **Now you are back to the original screen ready to enter your detail information for the claim.**
- **Again, using the sample Medicare EOMB from the opening page, enter the detail information for line 1 and then click on "ADD/EDIT" to add the Medicaid detail information for line 1. You must do this each line reported on the Medicare EOMB. In this sample, the basic detail line information has been added for each detail line.**

State of Missouri Medicaid

Other Payer Detail Information

Enter Other Payer(s) Detail Information for Medicare UB92 Part B Crossover claim.

Fields marked * must be filled in.

Claim Detail Line #1

Other Payer #1

Paid Date (mm/dd/yy)* 10 / 14 / 04

Group Codes, Reason Codes & Adjustment Amounts

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO-Contractual Obligation	097	99.00			

Add Reason Codes

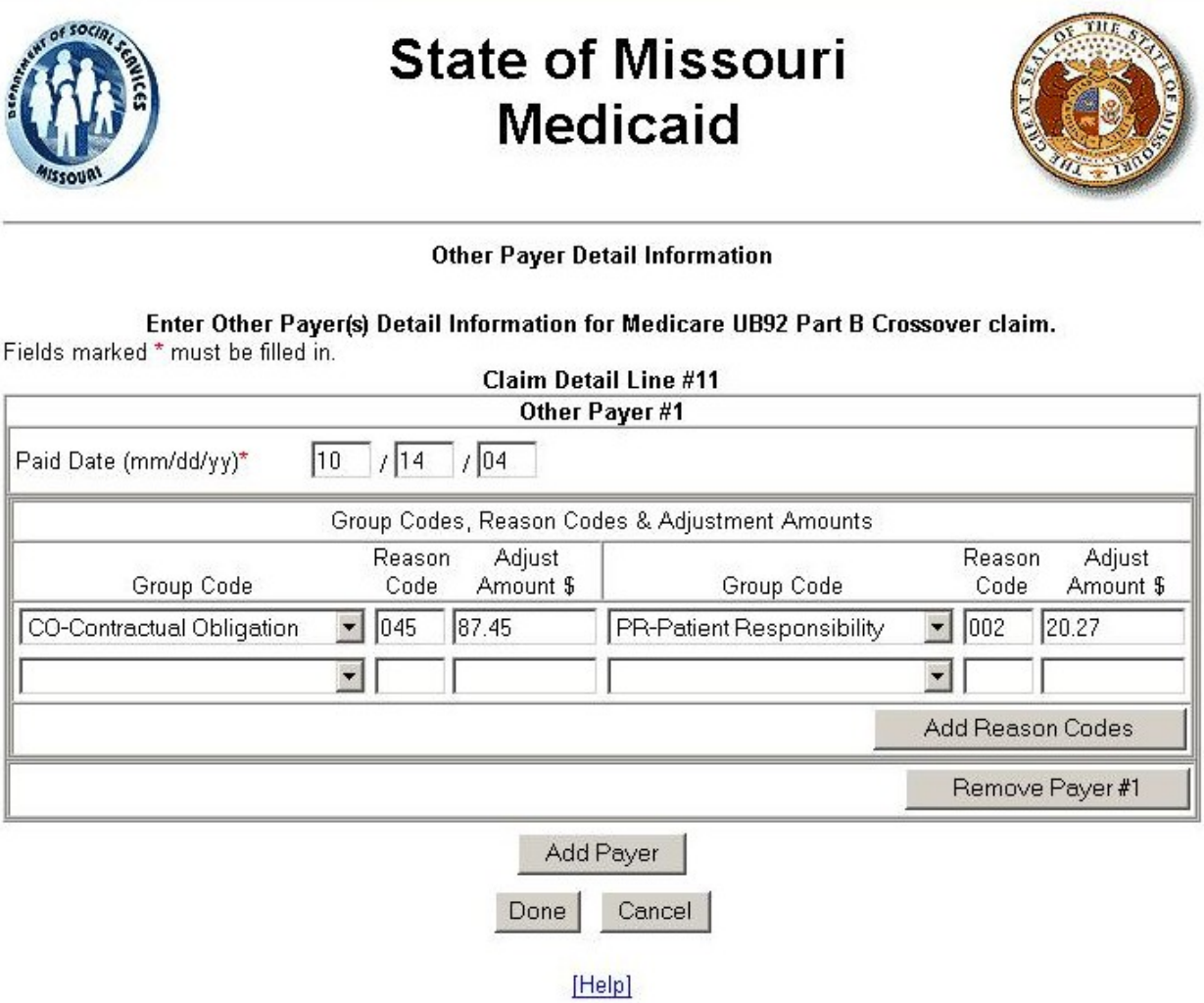
Remove Payer #1

Add Payer

Done Cancel

[Help]

- **Now you are on the Other Payer Detail screen. You must complete an Other Payer Detail screen for each line of your claim. Scroll to the bottom of the form and click on the 'Help' button, print off and save the instructions.**
- **Scroll back to the top, complete the Medicare paid date information as well as the Group and Reason Codes and Adjustment Amounts for line #1. See above sample. If the reason codes are not listed on your Medicare EOMB, choose the most appropriate code from the list of "Claim Adjustment Reason Codes" from the HIPAA Related Code List. For example, the code on the Claim Adjustment Reason Code list for deductible amount is 1 and for coinsurance amount is 2. Therefore, you would enter a Reason Code of '001' for deductible amounts and '002' for coinsurance amounts due. In this sample, the provider should report CO-97 and $99.00 as shown on the sample EOMB for line 1.**
- **The 'Adjust Amount' should reflect any amount not paid by Medicare including deductible, coinsurance and any non-allowed amounts.**



State of Missouri
Medicaid

Other Payer Detail Information

Enter Other Payer(s) Detail Information for Medicare UB92 Part B Crossover claim.

Fields marked * must be filled in.

Claim Detail Line #11

Other Payer #1

Paid Date (mm/dd/yy)* 10 / 14 / 04

Group Codes, Reason Codes & Adjustment Amounts

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO-Contractual Obligation	045	87.45	PR-Patient Responsibility	002	20.27

Add Reason Codes

Remove Payer #1

Add Payer

Done Cancel

[Help]

- **Enter a claim detail line for each line from your Medicare EOMB. All lines are not shown on this example.**
- **This is a sample detail entry for line 11 showing both contractual and patient responsibility codes and amounts.**
- **After all claim detail lines have been entered, click 'Done'.**

State of Missouri Medicaid

Medicare UB92 Part B Crossover

If you are not [redacted] please logout Logout

User: [redacted] Provider: 010000000 SAMPLE NUMBER

Fields marked * must be filled in.

Claim Frequency Type Code*: 1-Original	Provider Medicare Number*: 53xxx
Patient Name (Last Name, First Name)*: Shriek, Will	Patient Medicaid ID*: 99999999
Patient Medicare ID (HIC)*: 400000000A	Patient Account No.:
Resubmission Ref. No.:	Type of Bill*: 13-Hospital Outpatient
Diagnosis Codes* (Do not include the decimal): 1. 78652 2. 25000 3. 4019 4. 5.	Attending Physician ID*: 200000000

Surgery Procedure Code	Date (mm/dd/yy)	Surgery Procedure Code	Date (mm/dd/yy)
	/ /		/ /
	/ /		/ /
	/ /		/ /

Header Other Payers:* ADD/EDIT

Line No.	Revenue Code / Days/Units Billed*	From Date (mm/dd/yy)* / Thru Date (mm/dd/yy)*	Billed Charges $* / Paid Amount $*	Procedure Code* / Modifiers	Detail Other Payers
1.	0255 / 1	09/07/04 / 09/07/04	99.00 / 0.00	00000	ADD/EDIT
2.	0270 / 12	09/07/04 / 09/07/04	191.00 / 0.00	00000	ADD/EDIT
3.	0300 / 1	09/07/04 / 09/07/04	45.00 / 9.44	80053	ADD/EDIT
4.	0300 / 1	09/07/04 / 09/07/04	28.00 / 5.82	82550	ADD/EDIT
5.	0300 / 1	09/07/04 / 09/07/04	106.00 / 16.67	82553	ADD/EDIT

➢ **See Page 9 for instructions.**

6.	0300 1	09 / 07 / 04 09 / 07 / 04	112.00 9.66	84484	ADD/EDIT
7.	0300 1	09 / 07 / 04 09 / 07 / 04	69.00 11.22	85025	ADD/EDIT
8.	0300 1	09 / 07 / 04 09 / 07 / 04	104.00 10.59	85379	ADD/EDIT
9.	0300 1	09 / 07 / 04 09 / 07 / 04	20.00 4.59	85610	ADD/EDIT
10.	0300 1	09 / 07 / 04 09 / 07 / 04	36.00 8.66	85730	ADD/EDIT
11.	0320 1	09 / 07 / 04 09 / 07 / 04	128.00 20.28	71010	ADD/EDIT
12.	0350 1	09 / 07 / 04 09 / 07 / 04	809.00 121.61	71260	ADD/EDIT
13.	0450 1	09 / 07 / 04 09 / 07 / 04	302.00 164.01	99284 25	ADD/EDIT
14.	0730 1	09 / 07 / 04 09 / 07 / 04	53.00 15.39	93005	ADD/EDIT
					ADD DETAIL LINES

View Other Payers

Continue... Reset

[Home] [Help]

- **When you click "Done" on the last line detail entry screen, you will be brought back to the original screen which now should show the basic information for each detail line.**
- **Since you are now done entering the header and detail information, click on "Continue".**

State of Missouri Medicaid

Medicare UB92 Part B Crossover

If you are not [redacted], please logout Logout

User: [redacted] Provider 010000000

Please verify the values entered and click the Edit or Submit button.

Claim Frequency Type Code	**Provider Medicare Number**
1	53xxx
Patient Name (Last Name, First Name)	**Patient Medicaid ID**
Shriek, Will	99999999
Patient Medicare ID (HIC)	**Patient Account No.**
400000000A	
Resubmission Ref. No.	**Type of Bill**
	13
Diagnosis Codes	**Attending Physician ID**
78652 25000 4019	200000000
Surgery Procedure Code **Date (mm/dd/yy)**	**Surgery Procedure Code** **Date (mm/dd/yy)**

Header Other Payers: *Click 'View Other Payers'*

Line No.	Revenue Code / Days/Units Billed	From Date (mm/dd/yy) / Thru Date (mm/dd/yy)	Billed Charges $ / Paid Amount $	Procedure Code / Modifiers	Detail Other Payers
1.	0255	09/07/04	99.00	00000	*Click 'View Other Payers'*
	1	09/07/04	0.00		
2.	0270	09/07/04	191.00	00000	*Click 'View Other Payers'*
	12	09/07/04	0.00		
3.	0300	09/07/04	45.00	80053	*Click 'View Other Payers'*
	1	09/07/04	9.44		
4.	0300	09/07/04	28.00	82550	*Click 'View Other Payers'*
	1	09/07/04	5.82		
5.	0300	09/07/04	106.00	82553	*Click 'View Other Payers'*
	1	09/07/04	16.67		
6.	0300	09/07/04	112.00	84484	*Click 'View Other Payers'*
	1	09/07/04	9.66		

010000000

➢ **See Page 11 for instructions.**

7.	0300	09/07/04	69.00	85025	Click 'View Other Payers'
	1	09/07/04	11.22		
8.	0300	09/07/04	104.00	85379	Click 'View Other Payers'
	1	09/07/04	10.59		
9.	0300	09/07/04	20.00	85610	Click 'View Other Payers'
	1	09/07/04	4.59		
10.	0300	09/07/04	36.00	85730	Click 'View Other Payers'
	1	09/07/04	8.66		
11.	0320	09/07/04	128.00	71010	Click 'View Other Payers'
	1	09/07/04	20.28		
12.	0350	09/07/04	809.00	71260	Click 'View Other Payers'
	1	09/07/04	121.61		
13.	0450	09/07/04	302.00	99284	Click 'View Other Payers'
	1	09/07/04	164.01	25	
14.	0730	09/07/04	53.00	93005	Click 'View Other Payers'
	1	09/07/04	15.39		

View Other Payers

Edit Submit

[Home] [Help]

- **This brings you to a screen asking you to verify the information entered. Scroll to the bottom of the screen and click 'Help', print off and save the instructions.**
- **You can either edit the information or submit. Click on 'Submit'.**
- **If you click on "View Other Payers", the screens on pages 12 and 13 will open. See page 13 for instructions.**

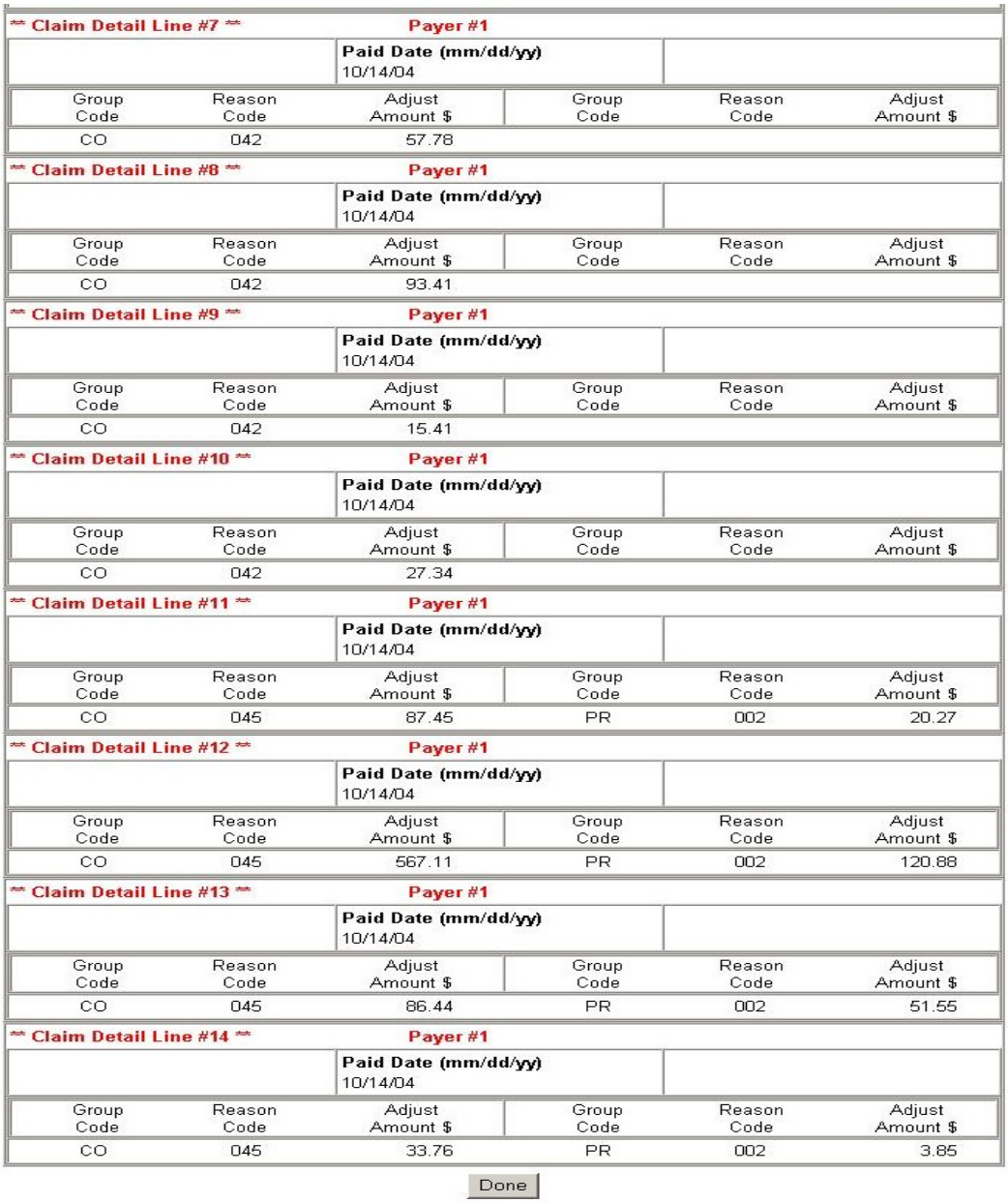
State of Missouri Medicaid

Other Payer Information

Other Payer Information for Medicare UB92 Part B Crossover claim.

** Claim Header **		Payer #1			
Filing Indicator MB		Other Payer Name Medicare			
Paid Amount $ 397.94		Paid Date (mm/dd/yy) 10/14/04		Medicare Claim No. 2042670099999	
Header Allowed Amount $ 397.94			Total Denied Amount $ 0.00		
Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
Remark Codes					
** Claim Detail Line #1 **		Payer #1			
		Paid Date (mm/dd/yy) 10/14/04			
Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO	097	99.00			
** Claim Detail Line #2 **		Payer #1			
		Paid Date (mm/dd/yy) 10/14/04			
Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO	097	191.00			
** Claim Detail Line #3 **		Payer #1			
		Paid Date (mm/dd/yy) 10/14/04			
Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO	042	35.56			
** Claim Detail Line #4 **		Payer #1			
		Paid Date (mm/dd/yy) 10/14/04			
Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO	042	22.18			
** Claim Detail Line #5 **		Payer #1			
		Paid Date (mm/dd/yy) 10/14/04			
Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO	042	89.33			

➢ **See page 13 for instructions.**



** Claim Detail Line #7 ** Payer #1

Paid Date (mm/dd/yy) 10/14/04

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO	042	57.78			

** Claim Detail Line #8 ** Payer #1

Paid Date (mm/dd/yy) 10/14/04

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO	042	93.41			

** Claim Detail Line #9 ** Payer #1

Paid Date (mm/dd/yy) 10/14/04

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO	042	15.41			

** Claim Detail Line #10 ** Payer #1

Paid Date (mm/dd/yy) 10/14/04

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO	042	27.34			

** Claim Detail Line #11 ** Payer #1

Paid Date (mm/dd/yy) 10/14/04

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO	045	87.45	PR	002	20.27

** Claim Detail Line #12 ** Payer #1

Paid Date (mm/dd/yy) 10/14/04

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO	045	567.11	PR	002	120.88

** Claim Detail Line #13 ** Payer #1

Paid Date (mm/dd/yy) 10/14/04

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO	045	86.44	PR	002	51.55

** Claim Detail Line #14 ** Payer #1

Paid Date (mm/dd/yy) 10/14/04

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO	045	33.76	PR	002	3.85

Done

- **If you clicked on "View Other Payers", the screens on pages 12 and 13 open. These screens let you see the detail information you entered for the header and line level details on the previous screens. Not all detail lines are shown on this sample because of Medical Services' computer screen capture limitations (line 6 is missing). You can print this for your records.**

State of Missouri Medicaid

Medicare UB92 Part B Crossover

If you are not [redacted], please logout Logout

User: [redacted] Provider: 010000000

Thank you. Your claim has been received.

Claim Frequency Type Code 1	**Provider Medicare Number** 53xxx
Patient Name (Last Name, First Name) Shriek, Will	**Patient Medicaid ID** 99999999
Patient Medicare ID (HIC) 400000000A	**Patient Account No.**
Resubmission Ref. No.	**Type of Bill** 13
Diagnosis Codes 78652 25000 4019	**Attending Physician ID** 200000000
Surgery Procedure Code **Date (mm/dd/yy)**	**Surgery Procedure Code** **Date (mm/dd/yy)**

Header Other Payers: *Click 'View Other Payers'*

Line No.	Revenue Code / Days/Units Billed	From Date (mm/dd/yy) / Thru Date (mm/dd/yy)	Billed Charges $ / Paid Amount $	Procedure Code / Modifiers	Detail Other Payers
1.	0255	09/07/04	99.00	00000	*Click 'View Other Payers'*
	1	09/07/04	0.00		
2.	0270	09/07/04	191.00	00000	*Click 'View Other Payers'*
	12	09/07/04	0.00		
3.	0300	09/07/04	45.00	80053	*Click 'View Other Payers'*
	1	09/07/04	9.44		
4.	0300	09/07/04	28.00	82550	*Click 'View Other Payers'*
	1	09/07/04	5.82		
5.	0300	09/07/04	106.00	82553	*Click 'View Other Payers'*
	1	09/07/04	16.67		
6.	0300	09/07/04	112.00	84484	*Click 'View Other Payers'*
	1	09/07/04	9.66		

➢ **See Page 15 for instructions.**

7.	0300	09/07/04	69.00	85025	Click 'View Other Payers'
	1	09/07/04	11.22		
8.	0300	09/07/04	104.00	85379	Click 'View Other Payers'
	1	09/07/04	10.59		
9.	0300	09/07/04	20.00	85610	Click 'View Other Payers'
	1	09/07/04	4.59		
10.	0300	09/07/04	36.00	85730	Click 'View Other Payers'
	1	09/07/04	8.66		
11.	0320	09/07/04	128.00	71010	Click 'View Other Payers'
	1	09/07/04	20.28		
12.	0350	09/07/04	809.00	71260	Click 'View Other Payers'
	1	09/07/04	121.61		
13.	0450	09/07/04	302.00	99284	Click 'View Other Payers'
	1	09/07/04	164.01	25	
14.	0730	09/07/04	53.00	93005	Click 'View Other Payers'
	1	09/07/04	15.39		

View Other Payers

Next Print

[Home] [Help]

- **After submitting your claim, you will be brought to a screen which states, "Thank you. Your claim has been received". Click on the 'Print' button at the bottom of the screen to print off and save for your records.**
- **To enter another claim, click on 'Next'.**

SECTION 14
ADJUSTMENTS

Providers who are paid incorrectly for a claim should use the paper *Individual Adjustment Request* form to request an adjustment. Providers may also submit an individual adjustment via the Infocrossing Internet service, emomed.com, by using the claim frequency type option 7 for a replacement or option 8 for a void. Adjustments may not be requested when the net difference in payment is less than $4.00, or $.25 for pharmacy, per claim. If the adjustment is due to an insurance payment, or involves Medicare, the $4.00, or $.25, minimum limitation does not apply.

In some instances, more than one change may be necessary on a claim. **All** the changes to the claim must be addressed on the same *Individual Adjustment Request* form. Specify all the necessary changes, listing each change separately. Field 15 of the form may be used to provide additional information. **Only one claim can be processed per *Individual Adjustment Request* form as each adjustment request can only address one particular claim.** A separate *Individual Adjustment Request* form must be completed for each claim that requires changes, even if the changes or errors are of a similar nature or are for the same patient.

When using the Infocrossing Internet service to replace a paid claim using claim frequency type option 7, each line of the original paid claim must be re-entered even though a certain line or lines may not require an adjustment. A reprocessed Internet claim will have an ICN that begins with a “49”. Claim frequency type 8 is to be used only to void a previously paid claim and the payment is to be recouped. Claims voided through the Internet will appear on the next remittance advice with an ICN beginning with a “70”.

Providers submitting adjustment requests for changes in type of service codes or procedure codes must provide documentation for these changes. A copy of the original claim and the medical or operative report must be attached, along with any other information pertaining to the claim.

If an adjustment filed on paper does not appear on a Remittance Advice within 90 days of submission, a copy of the original *Individual Adjustment Request* and any attachments should be resubmitted. Photocopies are acceptable. Mark this copy with the word “Tracer”. Submitting another request without indicating it as a “tracer” can further delay processing. Adjustments for claim credits submitted via the Internet get a confirmation back the next day after submission to confirm the acceptance and indicate the status of the adjustment. If the Internal Control Number (ICN) on the credit adjustment is not valid, the confirmation file indicates such. If no confirmation is received, the provider should resubmit the claim credit.

See Section 4 of the Medicaid *Provider Manual* for timely filing requirements for adjustments and claim resubmissions. *Individual Adjustment Request* forms are to be submitted to the address shown on the form.

A sample Individual Adjustment Request is shown on the following page.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
MISSOURI MEDICAID

INDIVIDUAL ADJUSTMENT REQUEST

☐ UNDERPAYMENT ☑ OVERPAYMENT

TO FACILITATE PROCESSING, PLEASE ATTACH THE FOLLOWING:
1. Claim Copy
2. Remittance Advice Copy

FORWARD ORIGINAL TO:
ATTENTION: ADJUSTMENT UNIT
DIVISION OF MEDICAL SERVICES
P O BOX 6500
JEFFERSON CITY MO 65102

PLEASE ENTER THE FOLLOWING DATA FROM YOUR REMITTANCE ADVICE:

3. INTERNAL CONTROL NUMBER 1604274009019	6. RECIPIENT NAME Nelson, Harry
4. RECIPIENT MEDICAID NUMBER 12345678	7. REMITTANCE ADVICE DATE 09/10/2004

5. PROVIDER LABEL Second Street Hospital #019999999 486 Second Street First City, MO 80000	8. R.A. PAGE NUMBER 25

REFER TO PROVIDER MANUAL ADJUSTMENT SECTION FOR INSTRUCTIONS

	SERVICE DATE	INFORMATION ON REMITTANCE ADVICE	CORRECTED INFORMATION
8. QTY/UNITS			
9. NDC/PROCEDURE CODE			
10. SERVICE DATE(S)			
11. BILLED AMOUNT			
12. PAID AMOUNT	08/04/2004	$1,132.00	$0.00
13. PATIENT SURPLUS			
14. OTHER RESOURCES (TPL) (IDENTIFY SOURCE)			

15. OTHER/REMARKS

Billed Medicaid in error before billing commercial insurance. Please take back payment.

HELPFUL HINTS FOR FILING AN ADJUSTMENT REQUEST FORM

1. **Only one internal control number (claim) is allowed per request.**
2. **Only a *paid* claim can be adjusted. A denied claim *cannot* be adjusted (file a new claim with the corrected information on it.).**
3. **If you want Medicaid to recoup an entire payment, *do not* enter each line of the claim. Instead, complete the top of the form and line 12 only. Enter the date of service, the amount Medicaid paid, and a "0" in the corrected information field.**
4. **When a change to a claim is necessary, such as a service date or quantity, use the ICN of the claim that paid and file an adjustment request. Do not send a new claim as it will deny as a duplicate.**
5. **An ICN beginning with a "70" or "75" credits or recoups the original paid claim. An ICN beginning with a "50" or "55" repays the claim with the corrected information.**
6. **Use the 'Remarks" section of the form to explain the reason for the correction.**

16. PROVIDER'S SIGNATURE	TITLE	DATE
		10/13/2004

MO 886-1019E (4-96)

MO 8810

SECTION 15
SECOND SURGICAL OPINION

The intent of the Second Surgical Opinion Program is to provide an eligible Missouri Medicaid patient with a second opinion as to the medical necessity of certain elective surgical operations. When the second opinion has been obtained, regardless of whether or not it confirms the primary recommendation for surgery, the final decision to undergo or forego elective surgery remains with the Medicaid patient. A list of the outpatient surgical procedure codes requiring a second surgical opinion appears later in this section.

If a surgical procedure requiring a second opinion is performed in the hospital, either inpatient or outpatient, the physician performing the surgery is responsible for filing the second opinion form either on paper or electronically unless the surgery meets the following exceptions to the second surgical opinion policy. Hospital claims are subject to the second surgical opinion policy.

Hospitals must report inpatient surgeries on the UB-92 claim form using the ICD-9-CM surgical procedure codes. These codes are exempt from second surgical opinion editing and the hospital claim will process. However, the hospital remains subject to post payment review for the surgery and must assure that the physician performing the surgery has submitted an approved *Second Surgical Opinion* form and must keep a copy of the form in the patient's permanent file.

For outpatient surgeries, hospitals should report the surgery on the UB-92 claim form using the appropriate CPT procedure code(s). The procedure codes listed in this section require the proper completion and submission of a *Second Surgical Opinion* form. If there isn't an approved *Second Surgical Opinion* form on file, the claim for the outpatient surgery will deny. The hospital is subject to post payment review for the surgery and must assure that the physician performing the surgery has submitted an approved *Second Surgical Opinion* form.

Note – Anesthesiologists, assistant surgeons, independent laboratories, and independent x-ray services are exempt from the requirement to submit a copy of the *Second Surgical Opinion* form.

EXCEPTIONS TO SECOND OPINION REQUIREMENT

- Medicare/Medicaid crossover claims are exempt.

- Inpatient services are exempt from the second opinion requirement if the patient has Medicare Part B but not Part A. Enter "Medicare Part B only" in "Remarks" field of claim (field 84) on the UB-92.

- The *Second Surgical Opinion* form is not required if the surgeon does not participate in the Missouri Medicaid Physician Program. The provider must submit a claim along with a *Certificate of Medical Necessity* form and indicate on the *Certificate of Medical Necessity* form the surgeon's full name and indicate "non-participating."

- Those surgical operations specified are exempt from the second opinion requirement if any one of them is performed incidental to a more major surgical procedure that does not require a second opinion.

- If the service was performed as an emergency and a second opinion cannot be obtained prior to rendering the service, submit a paper claim along with a completed *Certificate of Medical Necessity* form indicating in detail the reason for the emergency provision of service. Emergency services are services required when there is a sudden or unforeseen situation or occurrence or a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

  1. Placing the patient's health in serious jeopardy; or
  2. Serious impairment to bodily function; or,
  3. Serious dysfunction of any bodily organ or part.

  Emergency requests suspend and are reviewed by a medical consultant. If the *Certificate of Medical Necessity* form is not attached, or the reason does not substantiate the provision of the service on an emergency basis, the claim is denied.

- The recipient was not eligible for Medicaid at the time of service, but was made retroactive to that time. If the provider is unable to obtain an eligibility approval letter from the recipient, the claim may be submitted with a completed *Certificate of Medical Necessity* form indicating the recipient was not eligible at the time of service, but has become eligible retroactive to that date. If the eligibility approval letter or the *Certificate of Medical Necessity* form is not submitted, the claim is denied. See Section 7 of the Medicaid *Provider Manual* for instructions for completing the *Certificate of Medical Necessity* form.

SURGERY CODES THAT REQUIRE A SECOND OPINION

The following CPT codes require a second surgical opinion and the submission of a *Second Surgical Opinion* form. Procedure codes marked with an "*****" also require the submission of an *Acknowledgment of Receipt of Hysterectomy Information* form.

28290	49491-50	49570	58260*	63003-62	63048
28290-50	49491-62	46570-50	58260-62*	63005	63048-62
28292	49491-6250	49570-62	58262*	63005-62	63055
28292-50	49495	49570-6250	58262-62*	63011	63055-62
28292-62	49495-50	49580	58263*	63011-62	63056
28292-6250	49495-62	49580-62	58263-62*	63012	63056-62
28293	49495-6250	49585	58267*	63012-62	63057
28293-50	49500	49585-62	58267-62*	63015	63057-62
28293-62	49500-50	49650	58270*	63015-62	63064
28293-6250	49500-62	49650-50	58270-62*	63016	63064-62
28296	49500-6250	49650-62	58275*	63016-62	63066
28296-50	49505	49650-6250	58275-62*	63017	63066-62
28296-62	49505-50	49651	58280*	63017-62	63075
28296-6250	49505-62	49651-50	58280-62*	63020	63075-62
28297	49505-6250	49651-62	58285*	63020-50	63076
28297-50	49520	49651-6250	58285-62*	63020-62	63076-62
28297-62	49520-50	49659	58290*	63020-6250	63077
28297-6250	49520-62	49659-50	58290-62*	63030	63077-62
28306	49520-6250	57240	58291*	63030-50	63078
28306-62	49525	57240-62	58291-62*	63030-62	63078-62
28308	49525-50	57250	58292*	63030-6250	63081
28308-62	49525-62	57250-62	58292-62*	63035	63081-62
47562	49525-6250	57260	58293*	63035-50	63082
47562-62	49550	57260-62	58293-62*	63035-62	63082-62
47563	49550-50	57265	58294*	63035-6250	63085
47563-62	49550-62	58265-62	58294-62*	63040	63085-62
47564	49550-6250	58120	58550*	63040-50	63086
47564-62	49555	58150*	58550-62*	63040-62	63086-62
47600	49555-50	58150-62*	58552*	63040-6250	63087
47600-62	49555-62	58152*	58552-62*	63042	63087-62
47605	49555-6250	58152-62*	58553*	63042-50	63088
47605-62	49560	58180*	58553-62*	63042-62	63088-62
47610	49560-50	58180-62*	58554*	63042-6250	63090
47610-62	49560-62	58200*	58554-62*	63045	63090-62
47612	49560-6250	58200-62*	59525*	63045-62	63091
47612-62	49565	58210*	59525-62*	63046	63091-62
47620	49565-50	58210-62*	63001	63046-62	63180
47620-62	49565-62	58240*	63001-62	63047	63180-62
49491	49565-6250	58240-62*	63003	63047-62	63182

63182-62	63191-62	63196-62	66840	66852-6250	66984
63185	63191-6250	63197	66840-50	66920	66984-50
63185-62	63194	63197-62	66850	66920-50	
63190	63194-62	63198	66850-50	66920-62	
63190-62	63195	63198-62	66852	66920-6250	
63191	63195-62	63199	66852-50	66983	
63191-50	63196	63199-62	66852-62	66983-50	

SECTION 16
RECIPIENT LIABILITY
State Regulation 13CSR 70-4.030

If an enrolled Medicaid provider does not want to accept Missouri Medicaid as payment but instead wants the patient (recipient) to be responsible for the payment (be a private pay patient), there must be a written agreement between the patient and the provider in which the patient understands and agrees that Medicaid will not be billed for the service(s) and that the patient is fully responsible for the payment for the service(s). The written agreement must be date and service specific and signed and dated both by the patient and the provider. **The agreement must be done prior to the service(s) being rendered.** A copy of the agreement must be kept in the patient's medical record.

If there is no evidence of this written agreement, the provider cannot bill the patient and must submit a claim to Medicaid for reimbursement for the covered service(s).

If Medicaid denies payment for a service because all policies, rules and regulations of the Missouri Medicaid program were not followed (e.g., Prior Authorization, Second Surgical Opinion, etc.), the patient is not responsible and cannot be billed for the item or service.

All commercial insurance benefits must be obtained before Medicaid is billed.

MEDICAID RECIPIENT REIMBURSEMENT (MMR)

The Medicaid Recipient Reimbursement program (MMR) is devised to make payment to those recipients whose eligibility for Medicaid benefits has been denied and whose eligibility is subsequently established as a result of an agency hearing decision, a court decision based on an agency hearing decision, or any other legal agency decision rendered on or after January 1, 1986.

Recipients are reimbursed for the payments they made to providers for medical services received between the date of their denial and the date of their subsequent establishment of eligibility. The recipient is furnished with special forms to have completed by the provider(s) of service. If Medicaid recipients have any questions, they should call (800) 392-2161.

SECTION 17
FORMS

On the following pages are copies of various forms used by the Missouri Medicaid program.

Certain Medicaid programs, services and supplies require the submission of a form before a claim can be processed for payment. Please note that several of the forms can be submitted electronically through the Infocrossing Internet service at www.emomed.com.

Acknowledgement of Receipt of Hysterectomy Information
Second Surgical Opinion
Sterilization Consent

If a form is submitted electronically, the provider **must** keep a paper copy of the form in the patient's medical record.

Copies of the forms are available from Medicaid from the following sources.

- Contact the Provider Communications Unit at 800/392-0938 or 573/751-2896.
- Go to the Medicaid website, www.dss.mo.gov/dms, and click on "forms" under the Provider Information heading.
- Use the Infocrossing order form found at the end of this section.

MO-8812

CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE.** I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____ (Month Day Year)

I, _____, hereby consent

of my own free will to be sterilized by _____ (doctor)

by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ Date _____
Signature (Month Day Year)

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

- ☐ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ _____
Interpreter Date

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ (name of individual) signed the consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____ _____
Signature of person obtaining consent *Date*

_____
Facility

_____
Address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

_____ , _____ ,
Name of individual to be sterilized *Medicaid number*

on _____ (Date of sterilization), I explained to him/her the nature of the sterilization operation _____ (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Gross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested).

- ☐ Premature delivery
- ☐ Individual's expected date of delivery:
- ☐ Emergency abdominal surgery:

(describe circumstances):

_____
Physician

_____ _____
Medicaid provider number *Date*

PSFL - 200
(Revised 11/01/00)

MISSOURI MEDICAID
CERTIFICATE OF MEDICAL NECESSITY

	Patient Name			Medicaid ID Number	
	TOS	Procedure Codes (Maximum 6)	Description of Item/Service	Reason for Service	Months Equip. Needed (DME only):
1.					
2.					
3.					
4.					
5.					
6.					

Attending/Prescribing Physician Name		Attending/Prescribing Physician Medicaid Number
Date Prescribed	Diagnosis	Prognosis
Provider Name and Address		Provider Medicaid Number
Provider Signature		

MO-8813 PLEASE SUBMIT THIS FORM FOR EACH PROCEDURE REQUIRING DOCUMENTATION OF MEDICAL NECESSITY DS1960 (09/01/02)

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
EXCEPTIONS UNIT

MEDICAID EXCEPTION REQUEST

RETURN TO: ATTN EXCEPTIONS UNIT
DIVISION OF MEDICAL SERVICES
PO BOX 6500
JEFFERSON CITY MO 65102-6500
FAX NO: 573-522-3061

ALL INFORMATION MUST BE SUPPLIED OR THE REQUEST WILL BE RETURNED

FOR LIFE THREATENING EMERGENCIES
CALL 1-800-392-8030

PLEASE TYPE OR PRINT

RECIPIENT NAME	DATE OF BIRTH

RECIPIENT MEDICAID NUMBER (DCN)	SOCIAL SECURITY NUMBER

RECIPIENT DIAGNOSES (MUST RELATE TO ITEM(S) OR SERVICE(S) REQUESTED)

LIST ALL APPROPRIATE ALTERNATIVE COVERED SERVICES ATTEMPTED AND FOUND INEFFECTIVE FOR THIS DIAGNOSIS.

REQUESTED ITEM(S) OR SERVICE(S) (INCLUDING DAILY QUANTITY)

DURATION OF NEED

MISSOURI MEDICAID PROVIDER WHO WILL BE DISPENSING AND BILLING FOR SERVICES (EX. DME PROVIDER)

NAME	TELEPHONE NUMBER
ADDRESS	PROVIDER NUMBER (IF KNOWN)
IS A HOME HEALTH AGENCY MAKING SKILLED NURSE VISITS? ☐ YES ☐ NO	AGENCY NAME
PRINT OR TYPE DOCTOR'S NAME OR ADVANCED PRACTICE NURSE'S (APN) NAME AND TITLE	TELEPHONE NUMBER
PRINT OR TYPE DOCTOR'S ADDRESS OR APN'S ADDRESS	FAX NUMBER
DOCTOR'S ORIGINAL SIGNATURE, OR APN'S ORIGINAL SIGNATURE AND TITLE (NO STAMPS OR PHOTOCOPIES) ▶	DATE

MO 886-3351 (3-02)

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES

MISSOURI MEDICAID INSURANCE RESOURCE REPORT

TPL-4

Submit this form to notify the Medicaid agency of insurance information that you have verified for a Medicaid recipient. Please send the completed form to:

Department of Social Services
Division of Medical Services
Attention: TPL Unit
P.O. Box 6500
Jefferson City, MO 65102-6500

DO NOT SEND CLAIMS WITH THIS FORM. YOUR CLAIM WILL NOT BE PROCESSED FOR PAYMENT IF ATTACHED TO THIS FORM.

PROVIDER IDENTIFICATION NUMBER	DATE (MM / DD / YY)
___ ___ ___ ___ ___ ___ ___ ___ ___	

PROVIDER NAME

CHECK THE APPROPRIATE BOX FOR THE REQUESTED ACTION

☐ ADD NEW RESOURCE OR ☐ CHANGE MEDICAID RESOURCE FILES

RECIPIENT NAME	MEDICAID I.D. NUMBER
	___ ___ ___ ___ ___ ___ ___ ___

INSURANCE COMPANY NAME

POLICYHOLDER (IF OTHER THAN RECIPIENT)	POLICYHOLDER'S SOCIAL SECURITY NUMBER

POLICY NUMBER	GROUP NAME OR NUMBER

VERIFIED INFORMATION

_____

_____

SOURCE OF VERIFIED INFORMATION: ☐ EMPLOYER ☐ INSURANCE COMPANY

TELEPHONE NUMBER OF CONTACT	DATE CONTACTED (MM / DD / YY)
( )	

NAME OF PERSON COMPLETING THIS FORM	TELEPHONE NUMBER

Do you want confirmation of this add/update?
(If yes, you **must** complete the name and address on back) ☐ YES ☐ NO

ATTACH A COPY OF AN EXPLANATION OF BENEFITS OR INSURANCE LETTER IF AVAILABLE

MO 886-2983 (2-97)

TO BE COMPLETED BY THE PROVIDER

If confirmation of this add/update is requested, please write the name and address of the person the confirmation should be sent to below. The TPL Unit will complete the bottom portion of this form and mail to the address shown.

_____

_____

_____

TO BE COMPLETED BY THE STATE

❑ Verification and correction as requested completed Date: _____

Insurance Begin Date: _____ Insurance End Date: _____

❑ Please resubmit claims

❑ Form not complete enough for verification by state - complete highlighted areas and resubmit

❑ TPL file already reflects the add/update. Our records were updated: _____

❑ Verification confirms Medicaid resource file correct as is - no update performed

❑ Change requested cannot be made. Reason:

_____

_____

_____

❑ Verification shows another current coverage that may be applicable:

_____

_____

_____

❑ Other: _____

_____

_____

_____

MO 886-2983 (2-97)

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES

MISSOURI MEDICAID ACCIDENT REPORT

Submit this form to notify the Medicaid agency of information you have regarding a Medicaid recipient's accident or injury. Please send the completed form to:

Department of Social Services
Divison of Medical Services
Attention: TPL Casualty/Tort Recovery
P.O. Box 6500
Jefferson City, Missouri 65102-6500

DO NOT send claims with this form. Your claims will not be processed for payment if attached to this form.

PROVIDER IDENTIFICATION NUMBER	DATE (MM/DD/YY)

PROVIDER NAME	DATES OF SERVICE

RECIPIENT NAME	MEDICAID NUMBER

DATE OF ACCIDENT/INJURY	APPROXIMATE TIME

TYPE OF ACCIDENT/INJURY

☐ AUTO ☐ WORK-RELATED ☐ OTHER (EXPLAIN)

ATTORNEY REPRESENTING RECIPIENT

RESPONSIBLE PARTY'S NAME	POLICY/CLAIM NUMBER

INSURANCE COMPANY NAME AND ADDRESS

HAVE YOU FILED A LIEN? IF YES, PLEASE PROVIDE DETAILS (I.E., AMOUNT, SERVICE DATES, ETC.)

☐ YES ☐ NO

REMARKS

Please attach copies of relevant documents (i.e. letters from attorneys, insurance companies, etc.) if applicable.

THANK YOU FOR YOUR ASSISTANCE.

MO 886-3018 (3-93) TPL-2P

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES

APPLICATION FOR PROVIDER DIRECT DEPOSIT

PLEASE TYPE OR PRINT IN BLACK INK ******SEE INSTRUCTIONS ON REVERSE SIDE******

SECTION A (All providers must complete this section)

1.TYPE OF DIRECT DEPOSIT ACTION➨ □ New provider/Re-enrollment ✦□ Cancel Direct Deposit ✦□ Change Account/Route number

2.PROVIDER NAME: Complete provider name below as shown on provider labels. **If the Application for Provider Direct Deposit is for a clinic or group,** this form must be accompanied by an Authorization by Clinic Members which **must** contain a list of the provider name(s) and number(s) of all Advanced Practice Nurses, CRNA's, Physicians, and Diabetes Self-Management Training providers employed at that clinic/group, along with the **ORIGINAL** signature of the clinic owner or administrator. All other providers **MUST** complete a **separate** Application for Provider Direct Deposit containing their individual provider number and ***original*** signature. The clinic Application for Provider Direct Deposit will not be processed without the completed Authorization by Clinic Members. **A separate Application for Provider Direct Deposit must be completed for each provider number assigned.**

TYPE OR PRINT PROVIDER NAME HERE ➨

3.PROVIDER NUMBER (enter provider number as shown on provider label, **one provider number per application**)

____ ____ ____ ____ ____ ____ ____ ____ ____

SECTION B (Complete this section if you wish to enroll in direct deposit OR a change in account/route number(s) is requested.)

(ATTACH a voided check showing the routing/account numbers, OR if checks are not used attach a letter from your bank, signed by the president or vice president of the bank, verifying the correct routing/account numbers, type of account, and financial institution completed below. The information completed on this form and the information on the attachment MUST match.

1. ROUTING NUMBER	2. DEPOSITOR ACCOUNT NUMBER
_____	_____

3. TYPE OF ACCOUNT (***must check one***) ➨ □ CHECKING ✦ □ SAVINGS

4. FINANCIAL INSTITUTION NAME	5. BRANCH NUMBER OR NAME (if applicable)
6. FINANCIAL INSTITUTION ADDRESS	7. TELEPHONE NUMBER (include area code)

SECTION C

I wish to participate in Direct Deposit and in doing so:

- ✦ I understand that in endorsing or depositing checks that payment will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State laws.
- ✦ I hereby authorize the State of Missouri to initiate credit entries (deposits) and to initiate, if necessary, debit entries (withdrawals) or adjustments for any **credit entries made in error** to my account designated above.
- ✦ I understand that the State of Missouri may terminate my enrollment in the Direct Deposit program if the State is legally obligated to withhold part or all payments for any reason.
- ✦ I understand that the Division of Medical Services may terminate my enrollment if I no longer meet the eligibility requirements.
- ✦ I understand that this document shall not constitute an amendment or assignment, of any nature whatsoever, of any contract, purchase order or obligation that I may have with an agency of the State of Missouri.

I am authorized to request Direct Deposit on behalf of this clinic/group and in doing so:

- ✦ I acknowledge that each individual in the clinic/group listed on the attached Authorization by Clinic Members has been informed of this request, and also informed that Medicaid funds will be sent to the depositor account specified above.
- ✦ I understand that each individual provider is responsible for all services provided and all billing done under the individual or clinic provider number, regardless to whom the reimbursement is paid. It is each individual provider's responsibility to use the proper billing code and indicate the length of time actually spent providing a service, regardless to whom the reimbursement is paid.

1. ❑ **I HEREBY CANCEL MY DIRECT DEPOSIT AUTHORIZATION** and authorize future payments to be sent to the current payment name and address recorded in the provider enrollment file. ***(Section A number 1 must also be completed)***

2. PROVIDER *ORIGINAL* SIGNATURE (*see requirements on reverse side of this form*)	TYPE OR PRINT NAME SIGNED & TITLE	3.DATE	4.TELEPHONE NUMBER

RETURN ORIGINAL FORM (and original Authorization by Clinic Members, if applicable) ***ALONG WITH A VOIDED CHECK OR LETTER FROM YOUR BANK (see Section B) TO:*** Division of Medical Services, Provider Enrollment Unit, PO Box 6500, Jefferson City MO 65102. Phone 573-751-2617

THIS FORM CANNOT BE FAXED

MO 886-3089 (3-2000) Page 1

APPLICATION FOR PROVIDER DIRECT DEPOSIT INSTRUCTIONS

SECTION A ***ALL providers must complete this section***

1. **Type of Direct Deposit Action** -Check appropriate box. **If canceling direct deposit you must also complete Section C, #1.**
2. & 3. **Provider Name and Provider Number** - Enter provider name **and** number **EXACTLY** as shown on your provider label.

SECTION B ***This section must be complete for new applicants or re-enrollments and any changes to your direct deposit information.

ATTACH a voided check showing the routing/account numbers, **OR** if checks are not used attach a letter from your bank, signed by the president or vice president of the bank, verifying the correct routing/account numbers, type of account, and financial institution **to the back of this form.** The information completed on this form and the information on the attachment **MUST** match.

1. **Routing Number** - Enter your financial institution's routing number as printed on the bottom left portion of your business checks or deposit tickets (the first 9 digits). See Examples 1 and 2 below.
2. **Depositor Account Number** - Enter depositor account number as printed on the bottom of business checks following the routing number. It may be the first series of digits after the routing number followed by your check number (example 1) or it may be the series of digits which follow your check number (example 2). NOTE: The check number is not included in the depositor account number.

EXAMPLE 1

FINANCIAL INSTITUTION CHECK NO.4444
HOMETOWN, USA

PAY TO ORDER OF _____

121456789 8765432109812 4444

↕ Routing No. ↕ Depositor Acct No. ↕ Check No.

EXAMPLE 2

FINANCIAL INSTITUTION CHECK 4444
HOMETOWN, USA

PAY TO ORDER OF _____

121456789 4444 8765432109812

↕ Routing No. ↕ Check No. ↕ Depositor Acct No.

*********Credit Unions and Savings and Loan Associations may differ from the above examples. Please VERIFY your DEPOSITOR ACCOUNT NUMBER and ELECTRONIC ROUTING NUMBER with your financial institution.*********

SECTION C

1. **TO CANCEL OR REDESIGNATE:** Complete and submit a new Application for Provider Direct Deposit with the changed information and forward to the Division of Medical Services. **You must check the *CANCEL* box if you wish to *CANCEL* your direct deposit, Section A number 1 must also be completed.** If you elect to cancel direct deposit future payments will be sent to the current payment name and address recorded in the provider enrollment file. Provider direct deposits will continue to be deposited into the designated account at your financial institution until the Division of Medical Services is notified that you wish to ***cancel or redesignate*** your account and/or financial institution.
   DO NOT CLOSE AN OLD ACCOUNT UNTIL THE FIRST PAYMENT IS DEPOSITED INTO YOUR NEW ACCOUNT.
2. **PROVIDER SIGNATURE** - If the provider is enrolled as an individual, he/she must sign the form. Nursing homes, hospitals, independent laboratories and home health agencies must be signed by a person listed on form HCFA-1513 (disclosure of ownership) section III (a). If enrolled as a clinic or business (except those listed above) the form must be signed by the person with fiscal responsibility for the same. **Clinic applications must be accompanied by the Authorization by Clinic Members which must contain** a list of the name(s) and provider number(s) of all Advanced Practice Nurses, CRNA's, Physicians, and Diabetes Self-Management Training providers employed at that clinic location. **The Application for Provider Direct Deposit and the Authorization by Clinic Members MUST be signed by the same person. All other providers must complete** a separate Application for Provider Direct Deposit containing their individual provider number and **original** signature. **A SEPARATE FORM MUST BE COMPLETED FOR EACH PROVIDER NUMBER ASSIGNED.**

OTHER

1. **ATTACH** a voided check showing the routing/account numbers, **OR** if checks are not used attach a letter from your bank, signed by the president or vice president of the bank, verifying the correct routing/account numbers, type of account, and financial institution **to the back of this form.** The information completed on this form and the information on the attachment **MUST** match.
2. Direct deposit will be initiated after a properly completed application form is approved by the Division of Medical Services and the successful processing of a test transaction through the banking system.
3. **This form must be used to change** any financial institution information **or to cancel** your election to participate in direct deposit.
4. The Division of Medical Services will terminate or suspend the direct deposit option for administrative or legal actions including, but not limited to, ownership change, duly executed liens or levies, legal judgements, notice of bankruptcy, administrative sanctions for the purpose of ensuring program compliance, death of a provider and closure or abandonment of an account.
5. If any information completed on this form cannot be verified from the attachments or the form is completed incorrectly, the form(s) will be returned without being processed for direct deposit.

MO 886-3089 (3-2000) Page 2

MISSOURI MEDICAID
SECOND SURGICAL OPINION FORM

PLEASE PRINT OR TYPE

SECTION I: TO BE COMPLETED BY PRIMARY (FIRST OPINION) PHYSICIAN — MO-8807

RECIPIENT'S NAME (FIRST) (M.I.) (LAST)				RECIPIENT'S MEDICAID I.D. NUMBER	
SURGICAL PROCEDURE DISCUSSED & RECOMMENDED			CPT-4 PROCEDURE CODES		ICD-9-CM DX. CODE
PERTINENT HISTORY SYMPTOMS AND PHYSICAL FINDINGS					
PHYSICIAN'S NAME (FIRST) (MI) (LAST)				Physician's Mo. Medicaid Provider No.	
PHYSICIAN'S OFFICE ADDRESS (Street) (City) (State) (Zip Code)				SPECIALITY, IF APPLICABLE	
APPOINTMENT DATE	PERSONAL SIGNATURE OF PRIMARY PHYSICIAN (NAME) (DATE)				

REFER THIS FORM TO THE SECOND OPINION PHYSICIAN WITH RESULTS OF PATIENT'S HISTORY AND PHYSICAL REPORT, LABORATORY DATA, X-RAYS, ETC. YOU SHOULD RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND POSSIBLE CLAIM FILING NEEDS.

SECTION II: TO BE COMPLETED BY SECOND SURGICAL OPINION PHYSICIAN

NEED FOR SURGERY ☐ CONFIRMED ☐ NOT CONFIRMED	STATE REMARKS:			
SURGICAL PROCEDURE RECOMMENDED, IF SURGERY CONFIRMED		CPT-4 PROCEDURE CODES		ICD-9-CM DX. CODE
SECOND OPINION PHYSICIAN'S NAME (FIRST) (M.I.) (LAST)				Physician's Mo. Medicaid Provider No.
SECOND OPINION PHYSICIAN'S OFFICE ADDRESS (Street) (City) (State) (Zip Code)				SPECIALITY, IF APPLICABLE
APPOINTMENT DATE	PERSONAL SIGNATURE OF SECOND OPINION PHYSICIAN (NAME) (DATE)			

REFER THIS FORM BACK TO THE PRIMARY (FIRST OPINION) PHYSICIAN REFERENCED IN SECTION I. YOU SHOULD RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND POSSIBLE CLAIM FILING NEEDS.

SECTION III: TO BE COMPLETED BY THIRD SURGICAL OPINION PHYSICIAN

(A third surgical opinion is covered by Mo. Medicaid only if the second surgical opinion physician did not recommend surgery)

NEED FOR SURGERY ☐ CONFIRMED ☐ NOT CONFIRMED	STATE REMARKS:			
SURGICAL PROCEDURE RECOMMENDED, IF SURGERY CONFIRMED		CPT-4 PROCEDURE CODES		ICD-9-CM DX. CODE
THIRD OPINION PHYSICIAN'S NAME (FIRST) (M.I.) (LAST)				Physician's Mo. Medicaid Provider No.
THIRD OPINION PHYSICIAN'S OFFICE ADDRESS (Street) (City) (State) (Zip Code)				SPECIALITY, IF APPLICABLE
APPOINTMENT DATE	PERSONAL SIGNATURE OF THIRD OPINION PHYSICIAN (NAME) (DATE)			

REFER THIS FORM BACK TO THE PRIMARY (FIRST OPINION) PHYSICIAN REFERENCED IN SECTION I. YOU SHOULD RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND POSSIBLE CLAIM FILING NEEDS.

SECTION IV: TO BE COMPLETED BY SURGEON, IF SURGERY IS PERFORMED AT REQUEST OF RECIPIENT

SURGICAL PROCEDURE PERFORMED				CPT-4 PROCEDURE CODES
ICD-9-CM DX. CODE	SPECIFY NAME AND ADDRESS OF SURGERY SITE			
DATE OF SURGERY				
SURGEON'S NAME (FIRST) (M.I.) (LAST)				Physician's Mo. Medicaid Provider No.
SURGEON'S OFFICE ADDRESS (Street) (City) (State) (Zip Code)				SPECIALITY, IF APPLICABLE
PERSONAL SIGNATURE OF SURGEON (NAME) (DATE)				

THE SURGEON MUST ATTACH THIS COMPLETED SECOND SURGICAL OPINION FORM TO HIS MEDICAID CLAIM FOR THE SURGICAL PROCEDURE. IT IS THE SURGEON'S RESPONSIBILITY TO FURNISH A COPY OF THIS COMPLETED FORM TO THE HOSPITAL/ AMBULATORY SURGICAL CARE CENTER, IN ORDER THAT THE FACILITY MAY BILL MEDICAID FOR RELATED CHARGES. YOU SHOULD RETAIN A COPY OF THIS FORM FOR YOUR RECORDS.

DS1907 (02/01)

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES

ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

This form must be completed when a hysterectomy is to be performed which is not precluded from Medicaid reimbursement under Federal regulatory provisions at 42 CFR 441.255(a) and which is not exempted from the requirement for this documentation under provisions at 42 CFR 441.255(d) or (e).

The requirement for Acknowledgement of Receipt of Hysterectomy Information applies to an individual of any age. The form must be signed by the recipient or her representative, if any, prior to the surgery. Hysterectomies for family planning purposes are not payable through Medicaid or any other federally funded program, nor from the general relief or blind pension programs.

1. NAME OF RECIPIENT	2. MEDICAID ID NUMBER	3. NAME OF REPRESENTATIVE

1. SOURCE OF HYSTERECTOMY INFORMATION

PART I
TO BE COMPLETED BY THE PERSON WHO SECURES THE AUTHORIZATION TO PERFORM THE HYSTERECTOMY

5. I certify that I have informed the above named recipient and her representative, if any, **orally and in writing,** that the hysterectomy will render her permanently incapable of reproducing. I further certify that the purpose for performing the hysterectomy is:

6. SIGNATURE AND TITLE OF PERSON SECURING AUTHORIZATION	7. DATE (MONTH/DAY/YEAR)

8. PHYSICIAN / CLINIC NAME	9. PROVIDER MEDICAID NUMBER
▶	

PART II COMPLETE A OR B

If B is completed, the reason the recipient is incapable of signing must be stated on the line provided in Item B. (B is not to be completed if the recipient is capable of signing in Item A.)

A. TO BE COMPLETED BY THE RECIPIENT RECEIVING THE HYSTERECTOMY PRIOR TO THE OPERATION

I have received, **orally and in writing,** information from the above named source, stating that the hysterectomy will render me permanently incapable of reproducing. I understand that I will not be able to become pregnant or bear children.

10. SIGNATURE OF RECIPIENT	11. DATE (MONTHIDAYNEAR)
▶	

B. TO BE COMPLETED BY A REPRESENTATIVE OF THE RECIPIENT RECEIVING THE HYSTERECTOMY

I, the representative named above, certify that the designated recipient accepts and understands that I am her representative and that she has received, **orally and in writing,** information from the above named source, stating that the hysterectomy will render her permanently incapable of reproducing. She understands that she will not be able to become pregnant or bear children.

12. REASON RECIPIENT INCAPABLE OF SIGNING

13. SIGNATURE OF REPRESENTATIVE	14. RELATIONSHIP TO RECIPIENT	1.5. DATE (MONTH/DAY/YEAR)
▶		

MO 886-3280 (11/01/00)

Forms Request

Provider Number: _____ Date: _____
(Or Affix Provider Label Here)

Provider Name: _____

Provider Phone: _____

CLAIM FORMS	Quantity Preprinted	Quantity Blank
A. Pharmacy		
B. Dental		
C. HCFA 1500 (Rev 12/90)		
D. HCFA 1450 (UB-92) Inpatient / Outpatient/ Home Health		
F. Prior Authorization		

CROSSOVER STICKERS

G. Hospital Crossover Sticker (BLACK)	
H. SNF Crossover Sticker (RED)	
I. Part B Crossover Sticker (BLUE)	

If provider labels are needed with blank Claim Forms (A-F), check box. ☐

If you checked box, an equal number of labels will be supplied with Forms A-F. If you DID NOT check box, you WILL NOT receive labels.

If provider labels are needed and you are not ordering Forms A-F, indicate the quantity _____

SPECIAL MAILING INSTRUCTIONS:

Name: _____

Attn: _____

Street Address: _____

_____
(Not P.O. Box)

City: _____

State: _____ Zip: _____

ADDRESS CHANGE / CORRECTION:

Provider Number: _____

Name: _____

Street Address: _____

_____
(Not P.O. Box)

City: _____

State: _____ Zip: _____

Effective Date of Change: _____

ATTACHMENTS	Quantity
J. HCY Medical Screening Tool (All Pages)	
HCY Screening Forms by Age Group	
2. Newborn - 1 month/2 - 3 months	
3. 4 - 5 months/6 - 8 months	
4. 9 - 11 months/12 - 14 months	
5. 15 - 17 months/18 - 23 months	
6. 24 months/3 years	
7. 4 years/5 years	
8. 6 - 7 years/8 - 9 years	
9. 10 - 11 years/12 - 13 years	
*. 14 - 15 years/16 - 17 years	
&. 18 - 19 years/20 years	
K. HCY Lead Risk Assessment Guide	
L. Sterilization Consent	
M. Acknowledge Hysterectomy	
O. Hearing Aid Evaluation	
P. Medical Necessity	
Q. Adjustment Request	
R. Medical Necessity Long Term HPN	
S. Second Surgical Opinion	
T. Medical Necessity - Abortion	
U. Hospice Election Statement	
V. Oxygen - Respiratory Justification	
W. Notification of Termination of Hospice Benefits	
Y. Insurance Resource Report (TPL-4)	
Z. Accident Reporting Form (TPL-2P)	
1. Physician Certification of Terminal Illness	

_____
* Provider Signature: (Must Be Provider's Original Signature)

All requests are delivered to the address on your current provider label unless an address change or correction is requested above. An address change or correction changes your provider billing label. If Special Mailing Instructions are indicated, this and all future requests for forms from Verizon Data Services are delivered to this address until notice of a change is received. A change to Special Mailing Instructions does not change your provider billing label.

The above forms are provided to all participating Missouri Medicaid Providers. They are intended solely for Missouri Medicaid claims filing. Please complete the above information and return it to Verizon Data Services via any paper claims submission P.O. Box. For information regarding electronic claims submission, contact Verizon Data Services at (573) 635-3559.

DS1054 (Rev 11/99)

NONDISCRIMINATION POLICY STATEMENT

The Missouri Department of Social Services (DSS) is committed to the principles of equal employment opportunity and equal access to services. Accordingly, DSS shall take affirmative action to ensure that employees, applicants for employment, clients, potential clients, and contractors are treated equitably regardless of race, color, national origin, sex, age, disability, religion, or veteran status.

All DSS contracts and vendor agreements shall contain non-discrimination clauses as mandated by the Governor's Executive Order 94-3, Article XIII. Such clauses shall also contain assurances of compliance with Title VI of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended/ the Americans with Disabilities Act of 1990 (ADA), as amended; the Age Discrimination Act of 1975, as amended and other pertinent civil rights laws and regulations.

Applicants for, or recipients of services from DSS who believe they have been denied a service or benefit because of race, color, national origin, sex, age, disability or religion may file a complaint by calling the DSS Office for Civil Rights at 1-800-776-8014. Complaints may also be filed by contacting the local office or by writing to:

Missouri Department of Social Services
Office for Civil Rights
P. O. Box 1527
Jefferson City, MO 65102-1527

Or

U.S. Department of Health and Human Services
Office for Civil Rights
601 East 12th Street
Kansas City, MO 64106

Additionally, any person who believes they have been discriminated against in any United States Department of Agriculture related activity (e.g. food stamps, commodity food, etc.) may write to the United States Department of Agriculture at:

USDA Office of Civil Rights
1400 Independence Ave., SW
Mail Stop 9410
Washington, DC 20250

This policy shall be posted in a conspicuous place, accessible to all applicants for services, clients, employees, and applicants for employment, in all divisions, institutions and offices governed by DSS.

Director, Department of Social Services

2004
Year

Forms Request

Provider Number: _____ Date: _____
(Or Affix Provider Label Here)

Provider Name: _____

Provider Phone: _____

CLAIM FORMS	Quantity Preprinted	Quantity Blank
A. Pharmacy		
B. Dental		
C. HCFA 1500 (Rev 12/90)		
D. HCFA 1450 (UB-92) Inpatient / Outpatient/ Home Health		
F. Prior Authorization		

CROSSOVER STICKERS

G. Hospital Crossover Sticker (BLACK)	
H. SNF Crossover Sticker (RED)	
I. Part B Crossover Sticker (BLUE)	

If provider labels are needed with blank Claim Forms (A-F), check box. ☐

If you checked box, an equal number of labels will be supplied with Forms A-F. If you DID NOT check box, you WILL NOT receive labels.

If provider labels are needed and you are not ordering Forms A-F, indicate the quantity _____

SPECIAL MAILING INSTRUCTIONS:

Name: _____

Attn: _____

Street Address: _____

_____
(Not P.O. Box)

City: _____

State: _____ Zip: _____

ADDRESS CHANGE / CORRECTION:

Provider Number: _____

Name: _____

Street Address: _____

_____
(Not P.O. Box)

City: _____

State: _____ Zip: _____

Effective Date of Change: _____

ATTACHMENTS	Quantity
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HCY Screening Forms by Age Group	
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3. 4 - 5 months/6 - 8 months	
4. 9 - 11 months/12 - 14 months	
5. 15 - 17 months/18 - 23 months	
6. 24 months/3 years	
7. 4 years/5 years	
8. 6 - 7 years/8 - 9 years	
9. 10 - 11 years/12 - 13 years	
*. 14 - 15 years/16 - 17 years	
&. 18 - 19 years/20 years	
K. HCY Lead Risk Assessment Guide	
L. Sterilization Consent	
M. Acknowledge Hysterectomy	
O. Hearing Aid Evaluation	
P. Medical Necessity	
Q. Adjustment Request	
R. Medical Necessity Long Term HPN	
S. Second Surgical Opinion	
T. Medical Necessity - Abortion	
U. Hospice Election Statement	
V. Oxygen - Respiratory Justification	
W. Notification of Termination of Hospice Benefits	
Y. Insurance Resource Report (TPL-4)	
Z. Accident Reporting Form (TPL-2P)	
1. Physician Certification of Terminal Illness	

_____
* Provider Signature: (Must Be Provider's Original Signature)

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DS1054 (Rev 11/99)

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All DSS contracts and vendor agreements shall contain non-discrimination clauses as mandated by the Governor's Executive Order 94-3, Article XIII. Such clauses shall also contain assurances of compliance with Title VI of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended/ the Americans with Disabilities Act of 1990 (ADA), as amended; the Age Discrimination Act of 1975, as amended and other pertinent civil rights laws and regulations.

Applicants for, or recipients of services from DSS who believe they have been denied a service or benefit because of race, color, national origin, sex, age, disability or religion may file a complaint by calling the DSS Office for Civil Rights at 1-800-776-8014. Complaints may also be filed by contacting the local office or by writing to:

Missouri Department of Social Services
Office for Civil Rights
P. O. Box 1527
Jefferson City, MO 65102-1527

or

U.S. Department of Health and Human Services
Office for Civil Rights
601 East 12th Street
Kansas City, MO 64106

Additionally, any person who believes they have been discriminated against in any United States Department of Agriculture related activity (e.g. food stamps, commodity food, etc.) may write to the United States Department of Agriculture at:

USDA Office of Civil Rights
1400 Independence Ave., SW
Mail Stop 9410
Washington, DC 20250